Migration and work-related health in Europe

- a pilot study

Karen Wren and Paul Boyle

University of St Andrews
Scotland
SALTSA is a collaboration programme for occupational research in Europe. The National Institute for Working Life in Sweden and the Swedish confederations of trade unions Saco (the Swedish Confederation of Professional Associations), Lo (the Swedish Trade Union Confederation) and Tco (the Swedish Confederation of Professional Employees) take part in the programme. Many problems and issues relating to working life are common to most European countries, and the purpose of the programme is to pave the way for joint research on these matters from a European perspective.

It is becoming increasingly obvious that long-term solutions must be based on experience in and research on matters relating to working life. SALTSA conducts problem-oriented research in the areas labour market, employment, organisation of work and work environment and health.

SALTSA collaborates with international research institutes and has close contacts with industry, institutions and organisations in Europe, thus linking its research to practical working conditions.

Contact SALTSA

Labour Market Programme
Lars Magnusson, National Institute for Working Life, Tel: +46 8 619 67 18, e-mail: lars.magnusson@niwl.se
Torbjörn Strandberg, LO, Tel: +46 8 796 25 63, e-mail: torbjorn.strandberg@lo.se

Work Organisation Programme
Peter Docherty, National Institute for Working Life, Tel: +46 8 730 96 03, e-mail: peter.docherty@niwl.se
Mats Essemyr, Tco, Tel: +46 8 782 92 72, e-mail: mats.essemyr@tco.se

Programme for Work Environment and Health
Per Malmberg, National Institute for Working Life, Tel: +46 8 619 67 10, e-mail: per.malmberg@niwl.se
Anders Schaerström, Saco, Tel: +46 8 613 48 74, e-mail: anders.schaerstrom@saco.se
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Foreword

Work-related health among migrants has been identified as an important research gap in Europe at a time, which is witnessing a significant increase in mobility, involving both voluntary and forced migration. While the numbers of forced migrants seeking asylum in Western Europe have increased significantly since the mid 1980s, the EU is also becoming more integrated as a labour market, resulting in a more mobile workforce. The coming decades are likely to see further increases in labour migration as demographic changes are predicted to aggravate pre-existing labour shortages in certain skilled sectors. This is likely to lead to further increases in migration from other continents and within the EU – which in a not too distant future will include several countries in Central and Eastern Europe. Therefore, studies of migration and working life have been prioritised in the SALTSA programme.

Despite these trends, very little is known about the work-related health implications for migrants and the related implications for European societies. Work-related health aspects include occupational accidents among ethnic minorities employed in dangerous occupations as well as work-related stress among skilled migrants in qualified positions. A potential health hazard is de-skilling among skilled refugees, unable to perform their professions. To date, a major problem preventing research and more full awareness of these linkages is the difficulty of acquiring relevant data, and in particular, data which could be compared internationally.

Now, if one cannot use any already existing data, one still has to start somewhere in order to collect information and possibly gain knowledge. Thus SALTSA has endeavoured to lay a foundation for future research by exploring the topic in a step-wise fashion. In a planning phase during 1998 and 1999 a search for references and contacts was made and two workshops were arranged. The result of the study and one workshop have been documented in other SALTSA publications. Another outcome of this phase was a network of researchers.

The objective of the following phase was to assess the feasibility of meaningful comparative European research on the situation of different groups of migrants versus non-migrants in terms of work and health by searching for databases and other sources of information as well as academic competence and other contacts. This highly useful overview has been documented in a separate report.

Finally, a pilot study was carried out. It was based on in-depth interviews with migrants selected to represent intra-EU-migration, migration from an EU applicant country and refugees. Since the number of interviewees would not allow any quantitative conclusions, the objective was to explore the types of work-related health problems that actually occur among migrants today and to gain some insight in the causal processes behind them, rather than to estimate the scope of these problems. The result that is documented in this report is a systematic description and analysis, underpinned with some vivid examples from real life.

This demanding task has been carried out on behalf of SALTSA by researchers at the School of Geography and Geosciences at the University of St Andrews, Scotland. We are deeply grateful for their huge efforts and valuable achievements and not least for having had the pleasure to co-operate with them. We would also like to express
our sincere thanks to the researchers of the International Organization for Migration in Italy and Statistics Sweden who have played a major role in the fieldwork.

*Per Malmberg*
Professor, Chairman SALTSA Committee for Work Environment and Health

*Anders Schærström*
Fil dr, Secretary SALTSA Committee for Work Environment and Health

**Other SALTSA reports on the same topic**


Introduction

This report follows from two earlier SALTSA reports (Wren and Boyle, 2001a, Wren and Boyle, 2001b) investigating aspects of migration and work-related health in Europe. This topic has been prioritised by SALTSA as an important research gap in the European context, where significant increases in human mobility have created changing working conditions for many people. While political instability throughout the world has led to an increase in numbers of forced migrants seeking asylum in Western Europe during the last three decades, and removal of exit barriers from Central and Eastern Europe have also led to significant out-migration from that region, there have also been developments within the EU which have resulted in a more integrated European labour market, and greater mobility of labour within the EU. The category of ‘migrant’ therefore encompasses a very diverse range of people in terms of their origins and reasons for migrating, from the highly skilled migrants operating within an increasingly integrated EU labour market, to non-EU citizens from prospective EU member states, and forced migrants and refugees, who often face the greatest difficulty in re-establishing their working lives. There has also been an increase in the numbers of undocumented migrants working in some European countries, notably in Southern Europe and the UK. It has been the aim of this pilot study to attempt to capture various elements of this diversity, and to probe potential work-related health problems among some of these groups. While it is easy to categorise migrants by origins and perceived motives, the interview material shows that the situations of individuals are often more complex than simple classifications would suggest, and the reasons for migration can be unexpected and often multi-faceted. However, this pilot study is an attempt to draw out some important common and recurrent themes which have emerged through the interviews, and these themes will be used to highlight key areas of importance for future research.

This research is particularly timely in light of projected demographic changes, which will compound the growing skills shortages in some key employment sectors in Western Europe. As Western Europe’s population is projected to shrink over the next five decades, projections of population growth show that the economically active population will be too small to support welfare systems at their current levels (Salt et al., 1996). As a consequence there has been considerable interest in using controlled immigration to ameliorate shortages in particular occupational sectors. It is therefore important that policy-makers acquire some awareness of potential work-related health problems associated with increased human mobility. The incorporation of new countries into the EU is also likely to increase intra-EU mobility, thus increasing the likelihood of work-related health problems, and the situation of migrants from the former communist bloc countries currently working in the EU is therefore important in that it offers valuable insights into the types of problems which are likely to be experienced by migrants from new member states in the future.

While there has been considerable work on two of the three dimensions of migration, work and health (e.g. work on migration and health, migration and work, or work and health), few studies have tackled the complex relationship between these three aspects in combination. SALTSA, who initiated this research, recognised that due to the complexity of this topic, a collaborative multilateral approach would be a beneficial way to approach this topic. The early preparatory stages of this research therefore involved the establishment of an interdisciplinary network of researchers in Western Europe from a number of disciplines. This research network includes
participants from Britain, Sweden, Germany, The Netherlands, Denmark, Norway, Italy and Spain, and its early activities have been funded by SALTSA.

Methods

The pilot study builds on the findings of an earlier feasibility study carried out at the University of St Andrews, which established that current statistical data sources available in most European countries would be inadequate for linkages to be made between migration, employment and health, and that it would certainly be impossible to undertake cross-national comparisons due to international data incompatibility. As a result, the pilot study has been based on the use of qualitative in-depth interviews, which have been used to explore key issues related to migration, employment and health among a small number of migrants in three countries. The aim has been to provide a preliminary exploration of key issues and research questions which could potentially inform a larger, and more focused cross-national study on more specific aspects of migration and work-related health. At this early stage, the method used constitutes an active dialogue, where the participants can be active agents in moulding the future direction of a larger study, through helping to define major issues of importance to them. The study is also intended to highlight the way that certain processes operate in relation to the linkages between migration, employment and health, rather than a survey of the extent of any problems. Processes are difficult to uncover in quantitative studies, but are extremely important from a policy perspective, as to implement solutions to problems requires knowledge of how the problems manifest. The findings should therefore be viewed in this context, rather than as a representative quantitative exercise.

The selection of individual case studies has been guided by the need to capture the diverse experiences of migrants in various situations. The links between migration, employment and health have been explored in three countries: Britain, Sweden and Italy, through the use of a small number of in-depth interviews carried out among selected migrant groups. The aim was to conduct 24 interviews in each country, with eight in each of the following three groups: (1) intra-EU migrants – this varied by country, in Britain, Italian migrants were interviewed, in Sweden, British migrants and in Italy, Swedish migrants. (2) migrants from Poland (a prospective EU member state) (3) Bosnian refugees.

Sampling methods

The feasibility study highlighted major data incompatibility problems between countries, a factor which has had implications for potential sampling methods. Although it is not strictly necessary to implement rigorous sampling methods when conducting qualitative research, the selection of case studies aimed to achieve broad representation among respondents, particularly in relation to factors such as age, gender and residential location. Sweden has a comprehensive population register covering all residents in the country (including data on their country of birth and length of residence in Sweden) which has enabled non-random sampling by age, gender and residential location. The interviewees in Sweden were randomly selected from the population register, and approached and invited to be interviewed. Two major cities were selected for interviewing: Bosnian and British migrants were interviewed in Stockholm, while Polish migrants were interviewed in Malmö.
As neither Britain nor Italy have population registers, different sampling methods have been adopted in these countries. In Britain, a broad profile of the gender, age and residential areas of migrant groups (by nationality only) was established using the 1991 census to identify potential research areas (this could not be used for the Bosnian diaspora, which largely arrived in Britain after 1991). The census does not provide contact details for individuals, so snowball sampling methods were adopted, using key contacts in each community. This is a less rigorous method than that used in Sweden, however, a representative view was maintained by including incorporating gender and age into the sampling process, and by interviewing in different parts of the country. The interviews were conducted in London, Birmingham, Cambridge, Edinburgh and St Andrews.

In Italy, snowball sampling methods in the same way as in the UK. However, due to strong regional variations within Italy, sampling was initiated in 3 key regions: Lombardia (north), Lazio (central) and Apulia (south).

The shortfalls of using these methods should be borne in mind. Firstly, with snowball sampling methods, there is always a danger that the degree of self-selection among interviewees may affect the research findings. Although attempts were made to incorporate as wide a range of migrants as possible, well-established, skilled migrants are more likely to agree to be interviewed as they are more confident, have better language skills and are more likely to understand the value of social research. Also, they are often more easy to find. There are many newly-arrived migrants, potentially working illegally and or in poor or exploitative working conditions, who would be difficult to contact, and would be less likely to agree to be interviewed. This is also the case for people forced to work long hours for low pay, who may not have the time or inclination to be interviewed. In Britain, there were a high number of refusals among the Bosnians and the Poles, while no Italians declined to be interviewed at all. Although non-random sampling such as used in Sweden is more likely to cover a broader range of the migrant population, the same problem is also inherent in the refusal/non-response rate, which was quite high, particularly among the Bosnians. It should therefore be acknowledged that this study may have been unavoidably biased towards people who are ‘doing alright’. However, this method also has advantages, as in Italy and Britain, researchers using snowball sampling have been able to discuss work-related health issues with undocumented migrants working illegally, sometimes in poor and dangerous conditions. These migrant experiences could not be elucidated using official registers as a means of contact as it would have been impossible to reach these people, but their experiences are nevertheless very important.

The interviews
In-depth interviews formed the main part of the pilot study, and questions were loosely structured around the following key themes:

• Motives for migration
• Experience of resettlement programmes and refugee care
• Family context
• The role of networks
• Experience of adaptation
• Housing
• Employment – including details about changes in employment, work hazards, job security
• Discrimination
• Health problems – including discussion about possible causes, particularly if work-related or limiting ability to work
• Health care

The questions were structured in such a way that the interviewee would be able to express their views about related issues, and thus raise subjects which may not have been present in the literature. In this way, the interviews constituted an interactive dialogue, where interviewees had the opportunity to actively participate in the research agenda. Interviewees were offered translators where necessary, though in most cases, they were not actually required. The taped interviews were later transcribed, (translated if necessary) and analysed using NUDIST computer software, a package used for sorting and analysing qualitative material. All names have been changed to protect the identities of the interviewees.

**General health questionnaires**

As a supplement to the interviews, a short background questionnaire was administered to ensure the applicability of the questions asked, and to provide basic demographic indicators. In addition, two short health questionnaires were administered after the interviews. The first was a checklist of self-reported physical health problems, where the respondent could indicate any health problems and assess whether they were work-related. Although it is often not possible to identify the specific causative factors in disease, the questionnaire did allow some clear work-related health problems e.g. musculoskeletal disorders to be identified. The second was a standard hospital questionnaire used in the measurement and diagnosis of anxiety and depression (HADS – The hospital anxiety and depression scale) (Tab.1). The HADS scores provided a medically recognised measure of both anxiety and depression among respondents. The questionnaires were used to provide background information for the interviews, and were not designed to form any comparative measures of health, as the numbers involved in the study are small and would not be statistically significant.

*Table 1. Hospital Anxiety and Depression Scale (HADS)*

<table>
<thead>
<tr>
<th>Score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7</td>
<td>Normal</td>
</tr>
<tr>
<td>8-10</td>
<td>Mild</td>
</tr>
<tr>
<td>11-14</td>
<td>Moderate</td>
</tr>
<tr>
<td>15-21</td>
<td>Severe</td>
</tr>
</tbody>
</table>

Although these measures provide distinct categories for mental and physical health problems, it is not the intention of this study to make this sharp distinction, as examination of processes often demonstrate that these are linked. When dealing with migrant health care, it important to understand the way other cultures view health and health care as inter-linked. Measures of mental and physical health *are* used in the study, but the qualitative analysis, which forms the main body of the research, demonstrates how the physical and psychological aspects of health are linked.
Research Findings

The research findings have been organised around key themes which have emerged during pilot study. These themes have been selected on the basis that they have appeared consistently among a significant number of interviewees, and sometimes across countries, or that they have been identified as important in the literature. Issues around trade union membership have also been explored, as this project is funded by SALTSA, a partnership between the National Institute of Working Life and the Swedish Confederation of Employees. Work-related health is a matter which is prioritised by the unions. Despite the search for patterns of similarity across countries, it should be acknowledged that there are also very major differences between countries in terms of factors such as: immigration and asylum policy, the extent of illegal working, the nature of labour markets, quality of life and quality of health care. These differences will be addressed throughout the report. However, it is useful at this stage to contextualise the major themes by highlighting some major differences between countries and between migrant groups.

Intra-EU migrants
The motives for migration among this group were largely related to family migration and marriage, and not by labour market factors as suggested in literature. This group constituted primarily marriage partners and ‘tied’ migrants, although some were also related to labour market factors. Migration among this group had been relatively unproblematic, and often perceived as a positive step, though some adaptation problems were reported in the early stages. Most of the HADS scores for intra-EU migrants were within the normal range, however, surprisingly, most of the Italian migrants to Britain were experiencing mild to moderate anxiety at the time of interview. The factors associated with this will be explored in the course of the report. The majority of the Italians in Britain were highly skilled.

Polish migrants
Family migration also predominated within this group, although political and economic factors were also cited as important motivational factors in the migration process. Although some problems were reported in relation to deskilling, more substantial discussions centred around issues such as dangerous working conditions and dissatisfaction with health care provision. The HADS scores for the Polish migrants to all three countries were largely within the normal range.

Bosnian migrants
The Bosnians form a distinct group in that the majority of interviewees migrated within a short period of time around 1992. Displacement was sudden and unexpected, resulting in a diasporic group which encompasses all ages, and has a more even gender and socio-economic mix than other refugee groups, where migration is often selective and predominantly male (Wren, 1999). Most Bosnians were initially offered temporary protection (in the UK and in Sweden) or humanitarian status (in Italy) rather than full refugee status, while many who came to Britain were admitted under specific and often voluntary programmes to deal with medical emergencies. People granted temporary protection have later been offered full refugee status and the possibility of staying permanently.
In general the Bosnian migrants in all three countries showed high levels of anxiety and sometimes depression. In the UK, all the Bosnian interviewees had high anxiety scores, more so than those in Sweden and Italy. This may be attributable to the fact that Britain imposed stricter entry criteria on Bosnian refugees, and focused more on special needs cases such as medical evacuees, or on the voluntary activities of organisations who brought displaced Bosnians from temporary camps. Thus all of the Bosnian respondents in Britain had had direct experience of violence or war in Bosnia, while those in Sweden and Italy had largely escaped the worst incidents and were able to leave in family groups. Among the Bosnian interviewees in Italy, there were also a significant number of Roma people, an issue which will be discussed in the context of discrimination, due to the very severe discrimination and poor living conditions which they have experienced in Italy.

*Table 2. Overview of migration contexts of different migrant groups*

<table>
<thead>
<tr>
<th>From\To</th>
<th>Italy</th>
<th>Sweden</th>
<th>Britain</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bosnia</strong></td>
<td>Spontaneous refugee migration, mostly in family groups</td>
<td>Spontaneous refugee migration, mostly in family groups, family migration (before conflict)</td>
<td>Medical evacuation programmes, relocation of displacees already in refugee camps, some spontaneous migration after the conflict</td>
</tr>
<tr>
<td><strong>Poland</strong></td>
<td>Family and marriage, economic, career, political, to learn language, transit to USA, adventure</td>
<td>Family and marriage, economic, career, political</td>
<td>Family and marriage, economic, career, political, to learn language</td>
</tr>
<tr>
<td><strong>Italy</strong></td>
<td></td>
<td></td>
<td>Family and marriage, career, education, displacement related to sexual orientation, adventure</td>
</tr>
<tr>
<td><strong>Sweden</strong></td>
<td>Family and marriage, career, education, relocation through transnational companies</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Britain</strong></td>
<td></td>
<td>Family and marriage, relocation through transnational companies.</td>
<td></td>
</tr>
</tbody>
</table>
Health problems and quality of life

Figures 1-6 show the incidences of self-reported physical health problems in the three countries. One issue which emerged strongly, both in the general health questionnaires and in the interviews, was the comparative absence of health problems for all migrants living in Sweden. There were significantly fewer self-reported health problems among residents in Sweden, than for residents of the UK and Italy, and a sizeable proportion of these were reported by the Bosnians. This ties in with feedback regarding positive life quality factors discussed by migrants to Sweden, to the extent that sometimes earlier health problems had disappeared after migrating to Sweden. Factors such as shorter working hours and less stressful work environments, as well as cleaner air were quoted as important factors in the general well-being of respondents in Sweden. Very good occupational health services also seem to exist in Sweden, ensuring safety in the workplace and minimising the extent of work-related health problems.

The situation of migrants to Britain was varied, but Italian migrants generally considered themselves worse off in Britain in terms of general life quality, and suffered relatively high levels of anxiety after migration. A range of factors were stated as responsible, including high living expenses, lack of childcare and maternity leave, lack of sunshine, hectic lifestyle, and poor health care, though there did not seem to be any particular factors which were more important than others.

The situation in Italy was more varied, and there were no clear patterns in the interviews related to any of the above factors.

When viewing this data, it should also be considered that perceptions of health and illness vary with socio-cultural contexts. Some studies have shown that minority ethnic groups, when asked, are more inclined than the majority population to report their health status as bad (Ekberg, 1991; Appelquist, 1995; Leiniö, 1988), but this does not necessarily reflect actual differences. Self-estimated health may differ considerably from what is clinically observable, and it has been contended that “illness” is a subjective feeling of not being well, and that this feeling is interpreted by the patient on the basis of personal experience and culturally inherited attitudes (Löfvander, 1995; Elliot and Gillie, 1998; Sachs, 1987).

Overall, the majority of self-reported health problems overall were not related to work, but the most frequently occurring work-related health problems were musculoskeletal (particularly in Italy), along with sleeping problems. It may be that these problems are most easily attributable to work, while other health problems may be multi-faceted therefore difficult to categorise in this way. The Bosnians did not feature strongly in the incidence of work-related health problems (particularly as many were unemployed or in training or studying), although they are over-represented in the non work-related problems. It is therefore important to also consider the non work-related health problems as important, as even though they are not always related directly to work, they may be linked to earlier traumatic experiences and can act as barriers to employment.

Figures 1-6 (Following pages). The incidences of self-reported physical health problems in the three countries. With 8 individuals in each migrant group, the maximum number of reported cases could be 24.
Italy: non work-related health

- Back, shoulder or neck pain/injury
- Arm or hand pain/injury
- Leg pain/injury
- Breathlessness
- Poor hearing
- Poor eyesight
- Eczema/skin problem
- Migraine
- Asthma
- Hay fever/allergy
- Sleeping problems
- Eating problems
- Concentration problems
- Digestive disorders
- Bronchitis/emphysema
- Heart problems
- High blood pressure
- Diabetes
- Cancer
- Sleep problems
- Irritable bowel syndrome
- Digestive disorders
- Bronchitis/emphysema
- Heart problems
- High blood pressure
- Diabetes
- Cancer
Sweden: non work-related health

- Cancer
- Diabetes
- High blood pressure
- Heart problems
- Bronchitis/emphysema
- Digestive disorders
- Concentration problems
- Eating problems
- Sleeping problems
- Hay fever/allergy
- Asthma
- Migraine
- Eczema/skin problem
- Poor eyesight
- Poor hearing
- Breathlessness
- Leg pain/injury
- Arm/hand pain/injury
- Back, shoulder or neck pain/injury

Number of reported cases

Legend:
- Bosnians
- Poles
- British
Sweden: work-related health

- Back, shoulder or neck pain/injury
- Arm or hand pain/injury
- Leg pain/injury
- Breathlessness
- Poor hearing
- Poor eyesight
- Eczema/skin problem
- Migraine
- Asthma
- Hay fever/allergy
- Sleep problems
- Digestive disorders
- Concentration problems
- Eating problems
- Bronchitis/emphysema
- High blood pressure
- Heart problems
- Diabetes
- Cancer
- Heart problems
- High blood pressure
- Bronchitis/emphysema
- Digestive disorders
- Concentration problems
- Eating problems
- Sleeping problems
- Hay fever/allergy
- Asthma
- Migraine
- Eczema/skin problem
- Poor eyesight
- Poor hearing
- Breathlessness
- Leg pain/injury
- Arm or hand pain/injury
- Back, shoulder or neck pain/injury

Number of reported cases

- Bosnians
- Poles
- British
Britain: work-related health

- Back, shoulder, or neck pain/injury
- Arm or hand pain/injury
- Leg pain/injury
- Breathlessness
- Poor hearing
- Poor eyesight
- Eczema/skin problem
- Migraine
- Asthma
- Hay fever/allergy
- Asthma
- High blood pressure
- Heart problems
- Bronchitis/emphysema
- Digestive disorders
- Concentration problems
- Eating problems
- Sleeping problems
- Anorexia
- Eating problems
- Sleeping problems
- Concentration problems
- Digestive disorders
- Bronchitis/emphysema
- Heart problems
- High blood pressure
- Diabetes
- Cancer

Number of reported cases

- Bosnians
- Poles
- Italians
Themes

The following section will examine a range of themes which emerged from the interviews. Although this selection does not constitute comprehensive coverage of all of the material covered in the pilot study, these themes have been selected on the basis that they emerged consistently and among a relatively large number of interviews. The aim of presenting these themes is to establish the wider context within which work-related health problems occur, and to provide a coherent framework upon which further research can be based. Several themes have been explored which could potentially provide a basis for more focused projects in the future, looking at very specific aspects of work-related health among larger groups of migrants in the future.

Globalisation, transnationality and migration

Theories of international migration and integration, which have informed national policies, have been rooted in the idea that migrants make one monumental and relatively permanent move from one place to another and undergo a process of adaptation or integration. However, evidence from the pilot study confirms recent trends in the literature, indicating that globalisation and the free movement of labour within Europe have resulted in very complex and differentiated migration patterns which defy this conceptualisation. In particular, the intra-EU migrants in the study appeared to have very complex migration histories. This new complexity is encapsulated in the concept of transnationality. Transnationality is a theoretically complex set of ideas underpinning the changing social processes which accompany international migration, social processes which are rooted in but transcend nation states (Bailey, 2001). These processes are characterised by cross-border social relations, where people can participate in the normal activities of two or more countries (Portes, 1996). Theorists of international migration are now increasingly looking towards transnationality as a framework for migration research.

Two main threads can be drawn from this concept in relation to the pilot study. Firstly, the idea of a single monumental move from one country to another does not concur with the interviewees’ accounts. Often, there have been earlier stays in other countries, and migration patterns extend beyond the EU, often with links to the USA. These complexities are typified by the following accounts, where the most recent acts of migration have been part of a wider chain of migration events:

“I think we did it in an easy way, because although the UK and Ireland speak the same language, they are very different. Very different. They have a different money system... it’s a foreign country, and the different way of doing things, socially and in work. So that was a big transition. So, coming from there to Sweden I sort of already half got used to being away from home..... I find it more easy because I have lived in America, Australia and Japan, and they’re three different countries.” (Jane)

This trend can be further complicated by marriages which often occur during temporary periods abroad. This situation is typical, where an Italian woman is married to an American male and both are living and working in the UK:
“I chose to work in Britain because I was married to someone who had finished his PhD at Stanford, in San Francisco, America, and he got a teaching position at UCL. He had other options, but we thought that London would have been the best solution for both, where I could have found jobs easier than somewhere else. So this is why.” (Theresa)

The removal of exit barriers from Central and Eastern Europe has also generated more transient migration patterns, with less need to settle permanently, as this Polish migrant explained:

“It used to be the trend that people used to come here and stay here for quite a while because of the restrictions at the border, but since the visa stopped, you don’t need a visa in this country any more, you can come, you don’t have to get the visa to come, people are coming here and working for a few months and going back…It’s better because there’s this flow of people, there’s people coming out…. Those people who…..they used to stay here for two or three years, they would just change because they lived like rats. Three or four people in a room. It wasn’t a nice experience as a human being to live in such situations and they would work from 8 o’clock to 8 o’clock, 12 hours, that’s not very good. And being constantly on the go, on the go, on the go….and at weekends, what do they do? They get together and drink alcohol, so they don’t get any rest. They age very quickly, they get very unhealthy.” (Heinz)

This pattern of increased mobility was most frequently observed among intra-EU migrants, and also to a lesser extent among Poles. This change in patterns of mobility means that individual acts of migration are more likely to be linked to a chain of events, where often, aspirations are expressed to move to another new country, rather than constituting single monumental acts. Migrants are therefore more likely to view their situations as transient, which has obvious implications for the applicability of integration policies which aim to fully integrate migrants.

However, among the Bosnians, there was less evidence of such trends. Typically, the Bosnians moved once around the time of the of the conflict in Bosnia and remained in that country, though there were occasional exceptions. As already stated, this is not typical of refugee migration, where it is common for people to have been on the move for many years in a number of countries before seeking asylum in a specific country (Wren, 1999). Also, after asylum and citizenship have been granted, further international moves often take place.

These trends were reflected in the way international moves were perceived by migrants. This extends beyond the idea of ‘the myth of return’ which has existed in migration literature for decades, and which was evident in the interviews, where initial perceptions of movement often did not reflect longer term reality. This can be seen in the following reflections from intra-EU and Polish migrants:

“At the same time, I just thought I was coming here for my higher education, and then I would have gone somewhere else, or go back to Italy. So it wasn't this idea that I was going to stay. Now it's like, I turn back, and I think I've been here for 15-16 years, so it wasn't the idea of coming here as a migrant. In a way I was a migrant, but not .. So it was just a temporary thing, or something like that.” (Tina)
“I was quite happy about coming for a bit. I never thought I was going to move in. In fact, I moved back to Italy at one point, and then I came back, and even then I think I realised I was going to stay just about two or three years ago.” (Elena)

“I think that in my mind, I still had this feeling of going back to Poland, first of all because of the studies, you know. I really wanted to finish it. And secondly, I didn’t like it here so much, you know… so I didn’t think that I would stay here as long as this. It’s hard to say, but I think after some time you just take the days as they come, and you just live, and you adapt yourself to the situation and try to become one of those people who live here.” (Veronika)

Commentary from a Polish migrant encapsulated the transient state of his residence in Britain:

“And you know…I don’t feel like an immigrant, settling down and all that business. I’m on a permanent holiday here and I’ll stay as long as things work out.” (Jerzy)

This sense of transience in a sense encapsulates the situation of international migrants in a globalised economy, a reality which challenges more traditional conceptualisations of the migration process:

“Several generations of researchers have viewed immigrants as persons who uproot themselves, leave behind home and country, and face the painful process of incorporation into a different society and culture…. A new concept of transnational migration is emerging, however, that questions this long-held conceptualisation of immigrants, suggesting that in both the US and in Europe, increasing numbers of migrants are best understood as ‘transmigrants’” (Glick Schiller et al 1995:48)

The second aspect of transnationality which has emerged in the pilot study is evident in the way certain social processes become transnational after migration. In Sweden, UK migrants working for transnational companies were aware of the way their lives were in a sense being lived out in transnational space, where international norms were prevalent in the workplace rather than Swedish ones. The situation was similar within their wider social spheres, where networks of social contacts in Sweden were largely international and not Swedish. For others not working for transnational companies, the workplace was also described as transnational in nature, as this Polish academic related:

“In part because I had already become used to the Western way of living in the US.... and then the academic world is probably a bit special. You have contacts across borders and there are colleagues from other countries and you’re closed off a little maybe in your own world, where everyone in some way has the same interests. (Could you speak Swedish when you came here?) No, nothing. But that wasn’t a big problem…. English worked fine.” (Adam)

This Polish migrant describes a world in which the international cultural norms of his profession (the academic community) have more influence on his life than the norms of the country (Sweden) in which he lives. Within these transnational working and social spaces, the English language is often used as a medium for communication, and it is not always necessary to learn a new language.
Accounts from Swedes living in Italy showed a preference for working within Swedish companies or with Swedish consulates, thus maintaining cultural and linguistic contacts with Sweden. This work often entailed frequent trips home to Sweden, thus maintaining ties with the homeland and strengthening the linkages between the countries. This was perceived very positively by Swedes who often felt they had the best of both worlds.

In a sense, this transnational approach to working was more prevalent among skilled workers, many of whom already worked in transnational spaces prior to migration. They therefore have not faced the adaptation and language problems which other migrants have faced. This challenge to traditional conceptions of international migration ties in with other aspects of the transnational experiences of migrants. The linkages of peoples and processes across space and international borders has been documented by researchers who have identified the important role played by social networks in migrant communities.

Social networks

Social networks have been identified as a key factor in the processes related to transnationality, and embody the role of migrant agency in the formation of transnational communities. The role of social networks has long been recognised in migration literature, not only for labour migrant groups (Böhning, 1972; Hjarnø, 1988; Boyd, 1989), but also more recently for refugees (Escalona and Black, 1995; Koser, 1997). Research in the Netherlands, has demonstrated the important role of networks in providing capital to pay smugglers for relatives to leave Iran, and in the subsequent adaptation process (Koser, 1997). The role of migrant agency in the adaptation process is an important factor which receives differing emphasis in different parts of Europe. In Sweden (Hammar, 1993) and Denmark (Wren, 1999) the state carries out many of the processes involved in adaptation in the form of integration and refugee policies, which although valuable, can undermine the effectiveness of social networks to carry out these functions. In other countries such as Italy, where refugee care is less institutionalised, and largely left to voluntary agencies, the role of social networks becomes much more important.

Social networks fulfil a large variety of roles. Boyd (1989) distinguishes between ‘personal’ networks based on family, friendship and community ties, and networks of ‘intermediaries’ such as labour recruiters and traffickers. Boyd argues that social networks form the basis of most migration to the western world, and that in most countries, family-based migration predominates. Early migrant communities facilitate international movement by lowering the risks and costs associated with migration and increasing the potential economic gains (Massey, 1990; Massey et al, 1993). The networks, as well as facilitating further migration, can generate increased communication of all types between countries.

Within the pilot study, social networks have played a very important role. Specifically, migration among intra-EU migrants was overwhelmingly attributed to family factors and not labour market factors. However, this has not been in the context of extended social networks as described by Boyd. This migration has been more closely related to individuals, e.g. marriage, or to job opportunities available to close family members. Migration within Western Europe does not result in significant adaptation problems, and therefore the support roles normally provided by social networks are largely redundant. The Polish migrants in the study were more dependent on small-scale networks of relatives or friends and more likely to cite these as motivational factors in the migration process. However, the role of these networks
was different in respective countries. In Britain and Sweden, family contacts and networks were important in the early stages of migration:

“My friends came here before. They find me everything, house here, contacts, you know everything.” (Andrzej)

The supportive function in the early stages was typically replaced with a more social function over time:

“Then I met some Polish people, so it was alright, because during those times there was plenty of Polish people working in those places, fast food restaurants. So it was fun as well…… I’m just doing some cakes for Polish clubs now. I’m supplying them with the cakes, twice a week….. That’s why I love this area, because everything is in reach. Polish school, Polish community, Polish church, and the other school my daughter goes to is, as well, walking distance, you know. I never use the car.” (Buba)

However, in Italy, the situation among the Poles was completely different, as social networks with other Polish people were maintained for considerably longer. They were used more extensively to gain access to the labour market, both legally and illegally, and were maintained to promote further migration of relatives and friends from Poland through “a chain of social relations”.

The Bosnian refugees had networks which operated in a different way. It is only recently that migration literature has acknowledged the importance of social networks to refugees. This applies to both the migration channels and to subsequent adaptation processes. As stated earlier, the migration of Bosnians to Britain was characterised by special programmes, often for medical evacuees or people already internally relocated in refugee camps in Croatia. This created a very different set of circumstances than for the more spontaneous migration to Sweden and Italy. This has implications for the impact and roles of social networks. Among the Bosnians who migrated to Sweden and Italy, most people migrated in small groups or independently, but were either joining relatives already in these countries or were acting through information from people who had friends or family there. These social networks have therefore been instrumental in shaping the migration process, despite the fact that this was often undertaken at short notice. In Britain, this does not appear to have been the case due to the special circumstances and programmes which brought Bosnians to Britain. However, after migration, the Bosnians in all three countries appeared to have formed strong networks providing a range of supportive functions. Although earlier communities from Bosnia have subsequently been split up in Britain, reconstituted Bosnian communities have formed an extremely important supportive function. A range of Bosnian organisations throughout the country are linked together under a national umbrella organisation, providing a range of both social and supportive functions. These organisation have been organised and are maintained by Bosnians. This umbrella organisation brings Bosnians together from all over the country in an annual social event, which is a considerable achievement given the fragmented nature of the Bosnian diaspora in Britain, and it demonstrates the determination of the Bosnian community to form strong networks.
Plate 1. The annual 5 a-side football match in Birmingham, where Bosnians from all over Britain congregate once a year. Photo: Karen Wren

Plate 2. The après football party. This meeting is an important event for many Bosnians in Britain. Photo: Karen Wren
In addition, there were many smaller Bosnian organisations operating throughout the country. Those interviewed reported continuing links with other Bosnians in Britain, and many people married within these communities after migration:

“I know lots of people who came from the concentration camp, and other people, and I’m quite active in the Bosnian community. I have regular contact and friendship with lots of people, and regular contact with other Bosnian associations. Also we have some Bosnian parties, you know, with music, and lots of people came together and meet some people and even you knew in Bosnia but didn’t know that they were here.” (Senad)

In Italy, the Bosnians also formed supportive community networks which extended to finding work, in much the same way as the Polish networks in Italy. As responsibility for refugee care in Italy rests largely with voluntary organisations, social networks are a particularly important form of support which many of the Bosnians said they had benefited from.

In Sweden, networks also appeared to provide important supportive functions, particularly in relation to finding work. Social networks appeared to have shaped migration patterns of Bosnians to Sweden, many Bosnians have contact with relatives and friends who are also in Sweden. However, the degree of state involvement in the refugee resettlement process in Sweden means that many of the roles which can be carried out by social networks are diminished. Although official refugee care in Sweden is very comprehensive, the dispersal involved in housing allocation can also have negative effects:

“I had a very good life in my country. It isn't the same in Sweden. I haven't any friends. It doesn't work. I need a best friend like I used to have in my country. Someone to talk to, to share things with ... just she and I. That's what I miss……it's hard. Very hard. Everyone lives miles away. You only see people once every six months. It doesn't work.” (Fatima)

“It was my sister, she lived here, so I ... we said that if we could move to XXX it would be good for me. We didn't know anyone else. It feels very secure to live close to one of your countrypeople.” (Sabine)

Accounts from Bosnians suggest that networks are a more effective means of finding employment than official agencies, as these typical attempts to find practical work placements and jobs suggest:

“We had to fix it ourselves…. through contacts. A man we know who works in Stockholm, he comes from Hercegovina, from my home town, and he works at a legal firm in Stockholm. The school promised to help us find places, and I was hoping to get something in XXX, to cut down on travelling time but in the end they couldn't help, or it was too late.” (Sabine)

“I sent in lots of applications and things at that time. My brother was the first to get a job here in Stockholm and he has recommended me to people. That's the easiest way.” (Faruk)
“(So you have the same kind of job you had at home?) Yes. The same type of work. (How did you get that job?) I had a friend who worked there. And they called me every day. He called and said his boss wanted me to go along, but I told him I was a student, so I couldn't. I had to go to the course, or the social services ... if I take a day off, they stop my money. This went on every day for 5 or 6 months. He wanted me to go and see him.” (Zaim)

In this sense, excessive state involvement in the refugee resettlement process in the form of compulsory language classes was counterproductive, as the interviewee was prevented from taking up a job he had found through his own network of contacts, due to the compulsory language classes he was required to attend. Although the interviewees were very grateful to the help they had from Swedish society, there was some resentment over the way refugees were perceived essentially as victims who needed help rather than as capable and skilled people who could contribute productively to Swedish society:

“Yes, Sweden's... many people who moved here, saw it as a land of dreams, because you can settle here and live for 50 years without doing a single day’s work. I doubt whether there's another country in the whole world which can offer those conditions. It's nothing... that is if you give such a person, if this is how things are, it's not really a good thing..... You should give them a chance to live in a more normal way. Try to create more job opportunities and ... give people a chance to use the skills they used in their former lives so to speak. Before they arrived here, in some way.... you give people a false feeling of security. I wouldn't complain if I hadn't had it since we came. If we were forced to find for ourselves the things we need to survive, in fact I would be more satisfied than if it was as we have experienced things with everything served up on a plate.” (Cazim)

However, despite the highly supportive role provided by social networks, not all Bosnians were interested in maintaining contacts with other Bosnians. Some found it difficult and painful, preferring to mix with Swedes:

“I tried to comfort myself by meeting my countrypeople and talking, and then I became even more irritated, since I found out I had nothing in common with them. They thought I was stupid to study so much. Why do you study so hard? There's no hope of getting work. It's just a waste of time. This didn't make me feel better when I was with them ..........And at that time I was always with our neighbours from Sarajevo and all we discussed was the war, the war, the war, and what will happen now. Should we stay? Should we go back? Should we go on somewhere else?” (Lela)

“….it is better not to be together too much. It's a pity, but that's how it is.” (Zlata)

In Italy, the role of social networks was perceived as very important, especially in the absence of state support for refugee integration. It appeared that active social networks of extended family and friends formed a very important role in the migration process itself, and sustained future migration, but networks were also crucial in helping Bosnians once they were in Italy, particularly in relation to finding work. In fact, social networks appeared to be the main vehicle through which the Bosnians in Italy found work.
It should be noted that there are sub-divisions within the Bosnian community along the lines of religion, ethnicity, and social class. There have been obvious ethnic divisions related to the ethnic cleansing of groups from particular regions, but this has been complicated by mixed marriages. Further, in Italy, some of the Bosnians were in fact Roma people. These differences led to some variations in the ways people formed networks. The severe discrimination experienced by the Roma people in Italy, meant that they formed their own supportive networks separately from other Bosnians. Although religion did not emerge as important in many of the interviews, a small minority of very orthodox Bosnian Muslims in Britain formed broader networks based on religion with other Muslims. Muslims in western Europe have increasingly experienced discrimination and negative stereotyping, and this has been the context in which many Muslims have lived their daily lives in exile. Contact was made with practising Bosnian Muslims in Britain through a wider Islamic network and the account of one interviewee demonstrated a very different experience in exile from the others who were not particularly religious. The Bosnians in the study have not experienced racism in the same way as other refugee groups as their appearance is largely European, but the veil worn by many Muslim women signifies an ‘otherness’ which can attract hostility in a xenophobic environment. The interviewee recounted her experiences in London where she had been allocated social housing in a predominantly white area. She experienced two years of severe racial harassment by neighbours until she moved to a predominantly Muslim (largely Pakistani) area in another city. In this respect, a Muslim community was regarded as more important than a Bosnian community:

“Here there is a respect for….. we know other Pakistani families….. there is a respect here. When I came here, she (neighbour) said if you ever need anything, just tell me. You don’t need, but when someone just tell you….. big respect also, you know. If all people lived like this…. It would be good. (Farida)

Often, segregated residential areas with large minority ethnic populations are viewed as a negatively by the majority populations, but it should be remembered that in many European cities, members of ethnic and religious minorities are subjected to various forms of discrimination, as this case demonstrates, and this family found they had an infinitely better quality of life in a predominantly Asian/Muslim area. In general, however, the Bosnians in the study engaged in networks with other Bosnians rather than with other Muslims, and only a small minority of Bosnians would consider religious networks more important than Bosnian ones.

The role of social networks is clearly a positive factor which can help considerably in the adaptation process. There is sufficient evidence from the interviews to suggest that (with the exception of intra-EU migrants) networks have been very active in this way in all three countries. Finding employment has been a particularly important function carried out by social networks, even in Sweden where many of the functions of integration have become institutionalised and are considered to be within the sphere of the welfare system. There are therefore issues which have to be considered in relation to integration practices, and the extent to which these practices allow social networks to operate. Both Sweden and Britain have a high degree of state involvement in the refugee resettlement process, and have at various times adopted dispersal as a means of equitable resource distribution. Evidence from the pilot study would suggest that this could in fact be detrimental to the integration process as it removes the potentially supportive function that social networks provide. In addition, if one of
the major aspects of integration is finding work, and most refugees and migrants appear to find work through their own contacts rather than official agencies, then active dispersal appears not to be the most efficient method of integrating refugees. It would be more beneficial to both the receiver societies and to refugees to acknowledge the role of migrant agency in the integration process as a positive factor promoting integration. Watters considers dispersal, as practised in Britain, as “fundamentally disempowering” (Watters, 2001:1712) and having a negative impact on the ability of refugees to overcome mental health problems. Ager (1993) further argues that policies which promote rapid integration often have poor results in terms of mental health, and stresses the importance of allowing refugees to maintain their identities and networks. As Watters (2001) argues, it is often within the group context that real healing takes place after the traumatic dislocations experienced by refugees.

Social networks and health care
Access to health care can be an important determinant of health outcomes for any individuals, including migrants. The perceived quality of that care is therefore very important in determining how access takes place. One of the most unexpected but substantial findings of the pilot study has been related to migrant attitudes to health care in receiver societies, and the extent to which informal health care networks are used, particularly in the UK. Informal health care networks are integral to the concept of transnationality, as the way health care is accessed often transcends national boundaries. Evidence from the interviews shows fairly intense cross-border networks in operation, where migrants are referring to professional and non-professional sources of information about their health with people in their countries of origin, while treatment itself often takes place there too, either directly or indirectly. The use of such networks has been explained by two factors, firstly cultural differences in the way health care is administered and secondly, real problems with the quality of health care in some regions.

Cultural conceptions of ‘good’ health care
This aspect of health care should be of interest to medical practitioners dealing with migrant communities, as there is evidence that there are clear cultural differences in the way health care is administered in different countries. In general, Gupta (1991) reports that people from ethnic minority communities in Europe often try to solve psychiatric problems within their own communities before consulting official services. Personal accounts from the interviews relate that doctors, particularly in Italy, but also in Bosnia and Poland deal with patients in what is perceived to be a more caring and personal manner than in Britain and Sweden. Migrants who have been used to this more personalised form of interaction with their doctors find it difficult to adjust to the more impersonal and perfunctory style of care in Britain and Sweden. These differences were noted both by migrants who left Italy, and by Swedes who moved to Italy, the latter being particularly happy with the quality of their health care in Italy:

“Apart from medical examination and technical support, they look people in the eyes and ask patients how they really feel (in Italy), with regard to their relationships and private life. In Sweden they don’t, they are mere technicians.”
(Söderström)
Particular problems were identified by Italian migrants in the UK, who, overwhelmingly expressed dissatisfaction with health care in Britain, and the following accounts outline some of the problems:

“No, I feel very bad about saying this, because I think it's just really unfair. They're trying really hard, and these people are really nice individuals that do their best. The NHS is the thing I've been really, really disappointed with. I think it doesn't respond to me. It doesn't look after patients properly. It's very dismissive. You know, every time I have a problem with my kidney two out three times the response is 'Are you depressed? Do you want a pill?'”. (Elena)

One of the major criticisms of health care in Britain by the Italians was that it under-medicalised many conditions and was non-interventionist. Particular concerns were raised about the reluctance to carry out routine tests such as amniocentesis, smear tests etc., whereas in Italy, there would be a tendency to intervene at an earlier stage and engage in more preventative practices:

“It's just that preventative medicine is not really used in this country (Britain) very much, so they always do something eventually when you really are not well, rather than think ahead actually what this symptom could be.” (Tina)

“Well, in general I’ve got some biased feelings towards their system or their ideas (in Britain). I don’t know. It’s like they’re less interventionist than Italian doctors, I would feel. And they would give you paracetamol even if you twist your ankle, so paracetamol seems to be the only remedy, and they leave it very much to mother nature to heal the problems. You have to be very, very sick in order to trigger their intervention.” (Sofia)

“They're a bit understaffed in a way, but there's been more resources put in (in Italy) than the NHS (in Britain), so they will do by routine, for example, lots of test that they will not do here if it's not specifically asked, and even if it's specifically asked, they'll sort of say that they don't know.” (Tina)

“I actually hate the NHS at the moment. I really do. I think they haven’t got money. They’re very nice, but they haven’t got money, and they can be absolutely crap. And I think that it’s the first result. I think this is when you see the results of culture, so I think everything there is completely in a mess. And they’re really bad, because they are unreliable, too slow, and unless you’ve got life-threatening things their attitude is ‘Have some paracetamol and go home’. Whatever you come with. And it’s just maddening. They’ve been really bad when I was ill. (Elena)

“I wanted amniocentesis, which I did in the end, but they were really discouraging me a lot here in the NHS. ‘Are you sure? You're still young, 37, it's not old.' But they were obliged to offer it when you're 35. If you come before 35, then no. In Italy they do it when you are 32 or 33, if you ask. Then I discussed with my sister, and I said it's an expensive test. It more than £350-400, so if they do it as a routine, they will then shoot up their costs…. ” (Tina)

“I find it a bit annoying that there is a sense of non-action and non-intervention that is normal here, which is typical of British culture. Not to give antibiotics, for
instance. I've been very ill this year, which is not at all in my nature, just because they didn't give me antibiotics before and they let me go on without attacking a serious flu that I had. And that made me feel bad, and worse, probably. In Italy I would have had antibiotics before. Although I understand the philosophy at the base of it, I found it quite difficult to deal with.” (Theresa)

“They won’t do any test until the miscarriage possibility diminishes after 12 weeks. In Italy they do all the tests far earlier, so that they know whether it’s an ectopic pregnancy...... I will be going to Italy for an amniocentesis test because it can’t be done here before 12 weeks. Also, here, they only prescribe paracetamol. We have to have drugs sent from Italy. My previous doctor in Italy, who is also a friend, sends drugs.” (Elena)

“I think that in general health care is rationed in this country, so if you would want to get blood tests in this country you would have to make a very strong case to have them carried out and….Yes. They don't want to see you unless you have a very good reason. Just in general I think there is the feeling that even if you are able to access the service, the quality of it is highly variable.” (Giovanni)

“But I don't think that they...... You know, they see you very quickly, and you just feel that their mind is somewhere else. And I don't blame them, I mean, I know the problem with the NHS and they've got too many people, and they're understaffed, and not too many resources, and so on. OK and that's fine, but I don't think it's the best service, especially in comparison to the care I get in Italy.” (Tina)

Some of these issues were also raised by Bosnians, though not to the same extent:

“The thing is, the point is, I'm not happy, but I can't tell that he doesn’t treat us like every other patient. They do their bit. The only thing is that our doctors are a bit different…..I think our doctor would more easily send us to, you know, blood test, hearing test, or more, more sort of investigating the cases, but that’s my opinion.” (Sabit)

“When you go to the doctor and you tell him about the problems which you have, always the doctor gives you some painkillers. Always some painkillers. There is no question about what caused your problems. And always painkillers, and that's many times he give you .... try to go to the specialist. You know, that's a problem in this country, there is a few doctors for people. And you have to wait a long time to see a specialist for any problem.” (Amira)

However, the fact that health care in Britain is less interventionist and less medicalised in Britain was seen as advantageous in the sphere of maternity care, where feedback from Italians was generally positive:

“I mean, it's alright, and I think it's good that they undermedicalise a lot of things, for example pregnancy is very much undermedicalised, which I agree with…… it's also quite good here, because a lot is left with the midwives, rather than obstetricians or something like that, and I really like that, so I'm pro it, and I think I will be fine.” (Tina)
“Yes actually, I found that the midwife system is really much better than the Italian system. And also, maybe I'm particularly lucky, but they were really, really nice, professional, everything.” (Irene)

The above accounts demonstrate typical aspects of quality of care which were seen as problematic in Britain. However, there was a strong regional bias in the quality of care between London and the rest of the country. Interviewees in the London area reported very poor levels of care, in several respects, which also included maternity care:

“Of course we have bad maternity care in Italy, but the attention to the person, to the experience of both the mother and her baby here, as a concept is better, but the actual situation then turns out to be worse… You hear horrible stories about deliveries and a big number of ... for example, when we will have a baby, it is highly likely that we would go to Italy and have the baby down there. (What kind of problems have you heard about?) Very very difficult deliveries, people being neglected, no doctor being there. And a great number of cases I mean of various acquaintances, who say that basic standard of care is very bad, and their experience has been very bad.” (Giovanni)

Other areas of care cited as problematic included problems with access, waiting times and general quality:

“Yes, the problem is if we require help in an emergency. It's long waiting. Sometime what happens, you know, you're waiting a few hours for emergency, for example children and then they send you to GP. First go to GP, sometimes he gives me letters for children, not for myself, and then again I have to go to emergency. So the administration is not good.” (Senad)

The sense of dissatisfaction with the quality of the service, and the problems which that creates has implications for migrant health in general. If access to care is a problem for people in general in London, it is likely to be even more of a problem for migrants who are often negotiating problems with language, or even just understanding how the system works. Although most of the Italians interviewed were educated and skilled, this account highlights the impacts of health care problems:

“Until yesterday I had no sense of the fact that I could have had exemption from paying medicine, because they forgot to tell me, and they forgot to do my form… You really need to play the system and to be very good … I just cannot deal with it. I don't really understand how it works. My English disappears, and I need someone to deal with it, and I think I'M in a very privileged position. My English is fine. ... It's incredibly frustrating. I get very mad about it, and at the same time I feel very sad because I really believe in the idea of that. I believe that it should work, and that people shouldn't go privately. So it's been really, really, really frustrating. And I am actually thinking that I'd rather have my baby in Italy, if I could. So I just don't trust .... It's just so anonymous here.” (Elena)

In Sweden, problems were reported with the health care system, though to a lesser extent. Health care in the Stockholm region was often reported as very stretched, particularly in terms of waiting times. The views of respondents in Sweden were more differentiated than in Britain. There was a high degree of polarisation between people
who considered their care to be very good and others who considered it to be poor in some respects. Around half of respondents in Sweden were very positive about the quality of their care. This may be related to certain aspects of the health care system which appear to function well, while others are more problematic. Complaints in Sweden centred around the factors of excessive waiting times and lack of personal attention, particularly within primary care. The positive aspects were seen as hospital and maternity care. However, some interviewees seemed either not to understand the way the primary health care system works, or did not trust the quality of care there. Bosnians in particular often went straight to casualty for all treatment, even relatively minor conditions, thus bypassing the primary care system. The following account highlights most aspects of care which were perceived as problematic by a number (though by no means the majority) of respondents:

“All we tried the local clinic but we'd rather ... we go directly to XXX hospital every time something happens, we sit there in emergency for a few hours, but we always know we'll see a doctor straight away. You avoid ... seeing just anyone ...but it doesn't feel quite right, sort of, what happens when you are ill. I don't know why, but you would think that a country like Sweden should be able to keep the level of care ... the personnel were not very knowledgeable. ... You can see a pattern. We've been dissatisfied with all the doctors we've met even at XXX hospital.... in our country you always go to the doctor, you have a family doctor. And when you visit him he knows who you are. You are more than just a personal identity number on a bit of paper ... or a report, on a tape recorder, of what has happened, you actually have human contact with the doctor. This means you develop a relationship and you actually have faith in what the doctor tells you. We are not doctors, so we want to be told something we can understand. In Sweden it is so impersonal...... I could do as good a job myself as that doctor. I can also recommend aspirin. So if there is a problem we go straight to XXX hospital. At least something is done there. They examine patients in quite a different way.” (Cazim)

The perceived positive aspects of health care in Sweden were in the areas of hospital treatment and maternity care:

“I thought when ... the birth of the two children, I thought that was... and the help and the support was fantastic. Very gentle, very caring, very informative. Sometimes poorer than English, but not in the hospital. That was fantastic. The primary ... it’s the care where ... the little care, that has been the problem.” (Jane)

“And when my daughter was born. I was very impressed by the care then. They were extremely good. Very human and kind. I've no experience of what it's like in Britain on a delivery ward. In my experience of health care, I prefer the British style of care in hospitals. It feels different when you don't have to start by giving your personal identity number and paying. I don't like that, it feels all wrong. Of course, we pay in another way in Britain via national insurance.” (Mary)

Interviewees in Italy were generally very positive about the health care they received in Italy, and there was no evidence of any particular problems, however some interviewees reported that they did not have access to health care at all. This was sometimes related to their immigration status. Also, the respondents who were of
Roma origin reported that the care they received was not as good as they would have expected, and that doctors treated them in a dismissive way, often not examining them thoroughly. People with limited access to health care in Italy appeared to rely on voluntary provision or goodwill from Italian health care professionals and there was evidence of informal networks of care which operated outwith the official system.

**Informal health care networks**

In light of the obvious different cultural approaches to health care, and varying regional quality of care, interviewees were asked what strategies they adopted to ensure they received satisfactory health care. A considerable number (particularly in the UK) reported that they sought alternative forms of care outwith the biomedical system, including acupuncture, homeopathy, herbalism and Chinese medicine, mostly paid for privately. However, another common strategy emerged among Polish and Italian migrants, who obtained primary health care through transnational networks. This occurred either through access to health care in their country of origin or through the use of contacts who could provide advice they trusted, and sometimes also drugs. The following extracts demonstrate how these networks operated:

“Our access to health care takes place in our countries of origin, so, for example, if we need a dentist we’ll go to Italy…. I guess it’s very difficult to find out about the quality of doctors unless you’ve got some connections, and they recommend them. Either me or my parents or people who have lived there for quite a long time, so through word or mouth, you know, and through relatives’ experience, you know, you are looking for doctors for example …. but here, you wouldn’t know where to go, you just pick a number from the yellow pages. *(So you actually go to Italy for health care?)* For routine checks, like my wife’s seeing a gynaecologist in Italy…. so even periodical screening, smear test, we go down to Italy… because for example here they screen for cervical cancer every three years here, in Italy it’s every one year.” *(Giovanni)*

“I don't really go to my GP. I mean, if I'm really bad, maybe I will, but the first port of call is my sister, who is a medical doctor in Italy.” *(Tina)*

“I will be going to Italy for an amniosentesis test because it can’t be done here before 12 weeks. Also, here, they only prescribe paracetamol. We have to have drugs sent from Italy. My previous doctor in Italy, who is also a friend, sends drugs.” *(Elena)*

Much of the discussion so far has focused on Italians and Bosnians, but the Polish interviewees also developed complex networks of informal health care provision, albeit in a slightly different way. Most of the observations noted below came from Poles in the UK, but there was also evidence of similar processes operating among Poles in Italy. Polish perspectives on health care vary quite considerably from those in the other countries. Some of the criticisms of British and (sometimes) Swedish health care were similar to the comments made by Italians and Bosnians, where health care in Britain was seen as impersonal and non-interventionist. However, a further area of conflict emerged among the Poles. The culture of health care in Poland places the onus on individuals to identify their specific health problems and consult an appropriate specialist. This results in the acquisition of considerable knowledge about health care issues:
“Polish people are really, really strict about their health, so they know exactly what’s wrong with them. So doctors don’t particularly like Polish people. I’m sure you’ll find out about this. This is because of the Polish system. We never had GP system in Poland, we just got it now, like three years ago. So previously, you would have to know what’s wrong with you to go to the right doctor. So what the system was in Poland: If your throat would hurt, you’d go to nose, throat and ears specialist. If you would have a chest pain, you would go to someone else. If you would have a skin problem, you would go to a dermatologist. So exactly you would have to know what was wrong with you to go to the right doctor.” (Irena)

“I usually first contact my Polish friends, because in Poland, around health issues, there is a very different culture. In Poland everybody is so knowledgeable about health issues that you actually get treated by your friends. Some of my friends are doctors, and what they say….. In Poland, everybody comes to the doctor and they’ve already diagnosed themselves, so that’s what happens. So first we talk about it with friends, what it is and whether we can identify, and then we go to doctors.” (Buba)

The British system, where patients consult GPs for diagnoses, represented an area of conflict and often, dissatisfaction. The strategy of dealing with this was in most cases, as with Italians, to consult extended networks of both professional and non-professional contacts in Poland, as this typical case demonstrates:

“We are health conscious, most of us, and we will try to find any sort of herbal remedies, or go to Poland, where I call my sister and ask what she knows about the ailment we are suffering from. And then she will say, ‘Oh, I heard this about it, I heard about it’, you know, so then she will send me an antibiotic, perhaps better than the XXX here. Yes, because in Poland there are plenty of publications about health problems, and if there is let’s say, some sort of illness with the throat, there is a fantastic 24 hours working antibiotic, very strong one, but works wonders. So I will have it, and I will give it to my husband…. partner, and I will take it myself, and within 24 hours I am happy as a lark… We have a network of people who know a little bit of this and a little bit of that, and they always give us information and good news about what to take, about what to bring from Poland.” (Buba)

These networks function both in the provision of advice and of medicines themselves. Effectively, there is a great deal of self-prescription which goes on, and many circumvent national medical policies such as attempts to reduce antibiotic prescribing to avoid antibiotic resistance. However, the Polish networks differ from the Italian networks in that Italian networks operate across borders with actual travel to Italy for treatment, while the Polish respondents were more likely to use other means to access care from Poland, e.g. telephone and conventional post, and were less likely to be users of health care services in their countries of origin.

These trends also have to be considered in a gender and class context. In the case of Polish networks, it is very much the case that women make themselves aware of health issues on behalf of the family and mediate within these networks:

“So my husband, for example, he doesn’t know how many kidneys he’s got, because he’s never done biology in his O-levels, and that’s an exaggeration. He’s sort of not interested in biology and human anatomy, and obviously he doesn’t
know these things. But I know exactly where my liver is, my kidneys are, and everything else. So if I have a pain in my back, I’ll go ‘Ouch, I have to go and see someone who is responsible for the kidneys’, and GP doesn’t like it, because, you know, you’re not supposed to know where your kidneys are. They don’t like that. So we are a little, sort of, pushy about it.” (Irena)

“(If you’re ill, and anybody in your family is ill, who do you go to? Do you go to the GP?) My wife takes care of these things, so I don’t know.” (Andrzej)

This ties in very much with the traditional image of the Polish married woman whose role is perceived as essentially within the domestic sphere, taking care of the rest of the family. However, this image also has a class dimension, as the reports about health networks were primarily related by people of middle class origins. There was no evidence of the use of these networks among more recent migrants from Poland who were clearly economic migrants from less privileged backgrounds, who tended to use the health care services in Britain and Sweden uncritically. It may be the case that for some Poles, these support networks, such as contacts with doctors in Poland, were not available and for people on restricted incomes, it is often not financially possible to travel regularly to use health care in another country and maintain such networks, or to purchase drugs.

There was very limited use of health care networks by the Bosnians, despite the fact that a considerable number felt dissatisfied with their health care after migration. The upheavals in Bosnia would clearly have led to the severance of many ties with potential contacts in Bosnia, and subsequent limitations on personal financial situations after migration would be likely to prevent access to health care at home. Most Bosnians therefore used the health care services provided in receiver countries. However, a few Bosnians felt they had to return to Bosnia to use health care there as they were dissatisfied with the care they received in Sweden:

“I decided to go to Bosnia. I felt I had to see a doctor in my home country ... a doctor I knew. He looked at me, and said you have a problem with your goitre, but he didn't know exactly what. They saw everything on an X-ray. It was Graves disease.” (Asim)

The use of health care networks can be regarded as one aspect of an emerging pattern of transnationality, in the sense that health care is a highly personal matter which demands a great deal of trust, and therefore the best resources which are perceived to be available, even if this is in another country. Access to health care then often takes place in a manner which transcends national boundaries, and involves cross-border relations, where some migrants are participating in health care activities in more than one country simultaneously. This has repercussions for national health services, but also for the collection of national health data, which may not provide a full picture of migrant health and the treatment which is being administered to them. Any future study involving any aspect of work-related health among people who have migrated, must take into account the way health care is accessed and how the quality of this care is perceived.

**Family and ‘tied’ migration**

It is argued that the process of migration itself can be considered a pathogenic stressor (Mirdal, 1984; Gupta, 1991; Ekblad et al, 1999) causing ill health. Factors which can
lead to poor health include: cultural loss, post-migration stress and adaptation problems. Others place the emphasis on socio-economic factors such as downward social mobility (Smaje, 1995), though it is most likely that multiple interacting causes offer the most complete explanatory framework (Ineichen, 1989). However, for a considerable number of intra-EU migrants, the experience of migration was perceived as a positive opportunity to widen their horizons, enhance their careers and generally experience something new. Some short term negative effects were experienced, but people generally adapted fairly quickly, and did not suffer health problems as a result. The pilot study has demonstrated that, despite common perceptions of intra-EU mobility being related primarily to mobility of labour, it is family and ‘tied’ migration which is of overwhelming importance. This accords with Boyd’s (1989) observation about the role of social networks, however, marriage appears to be the primary motive for intra-EU migration in this study. The same can be said, though to a lesser extent, for Polish migrants, where marriage and inter-personal relationships have been one important factor among a number of motives for migration. Most of the EU migrants interviewed moved for the purposes of marriage, or as ‘tied’ partners of relocated workers on assignments. A minority migrated independently for work-related reasons. In a sense therefore, family migrants suffer some of the adaptation problems associated with other forms of migration, such as language barriers and career disruption, but unlike independent migrants, have immediate family connections to cushion the effects, both socially and financially. The families which moved within the EU on company assignments reported benefiting from a range of packages which cushioned the whole family from the social and financial effects of relocation. One female partner of a relocated British worker to Sweden reported:

“Financially you don’t have to work, because you’re so well taken care of. There is no pressure to have a dual income, as there is now, when we’re locally employed…… I just treated that part of my life like a long holiday, really.”

(Elizabeth)

However, partners who moved for the purposes of marriage experienced more problems, though these were often temporary and overcome relatively quickly. The Poles suffered more stress and found the whole process more of an upheaval than intra-EU migrants, as the following typical case demonstrates:

“No, it wasn’t difficult to fit in and everything. But at the same time it was really difficult. Moving from one country to another…. it’s a big step. And I didn’t know then whether I would be able to go back and see my family. I had a brother and my parents back in Poland. And that was really hard...... My future wife had learned Swedish and knew everything about how to get in touch with authorities ...... so there weren’t any problems like that. Of course there were problems.... but they were overshadowed by the biggest one of all......I couldn’t go back to Poland to see my family. It took 5 years before I could go back.... and that was the worst thing of all.” (Josef)

Migration and gender roles
The role of gender is particularly important in the context of family migration. Although the marriage partners who migrated were both male and female, there are specific issues related to gender roles which differ in each of the countries in the study, and these have had important effects after migration. Although the study is
primarily based on work-related health, the fact that many female migrants do not work is significant, particularly in cultures where the female spouse is perceived primarily as a wife and mother. To focus on labour market employment alone would be to ignore a large segment of the migrant populations in groups under investigation, people whose work is carried out in the domestic sphere.

In Sweden, most women are active participants in the labour market, and good childcare facilities exist to support this activity. Often this arises from financial necessity, but it has also become part of the culture of Swedish society. In Britain, this trend is less evident, although many more women are becoming active in the labour market, albeit on a part-time or low-paid basis. However, it is less common for mothers of young children to work in Britain than it is in Sweden. The situation in Italy seems to vary considerably by region so it difficult to generalise. Migrants from Poland related how in Poland, wives and mothers (particularly middle class women) are viewed primarily as homemakers, and their activity takes place mostly within the sphere of the home. The situation is very different for single women, and women from low-income households in Poland.

Migration and mixed marriages can impact the way both women, and men perceive their gender roles within the family, and their labour market participation and work-related health after migration. In Sweden, the socially constructed concept of mothers as ‘working women’ and equals in the labour market is interwoven with pedagogic ‘knowledge’ about what is best for children, i.e. institutionalised pre-school care. This is also accompanied by the assumed participation of the father as an active participant in the domestic sphere. British women however have, until recently, been more socialised into norms which view the woman primarily as a homemaker and mother, and although it has become quite normal and accepted for women to work, this is often perceived as a secondary role, and frequently involves part-time or low-skilled work. Institutionalised child care is not necessarily viewed as best for children, and ‘latchkey’ children, common in Sweden, are perceived as deprived and endangered in some way (leaving children unattended is in fact illegal in Britain). All of the British women in the study living in Sweden attempted to maintain their own ways of dealing with work and childcare, breaching Swedish norms and sometimes attracting criticism:

“They think you don't have anything to do all day ... you get told what to do, you do. “Oh, don't they have anyone to play with?” and things like that. They think that if you don't go to day care, they have no one to play with, but you have to then, as a stay-at-home mum it's not just handed to you, like you do when you're at day care... Yeah, it's not like it's just a continuous party. (Do you think if you'd stayed in England, do you think you would have lived differently there than here in Sweden?) No, I would have been at home, because that's more common in England. That's the way it is. Mum is home with her kids. There's more and more of it now, mum out working, but usually they wait until the kids start school, and you start school when you're five ... There's no after-school recreation centre, but the school day is longer, so you can easily have a part-time job starting when your children are five. And then there's also .... I’ve read in a few articles that there is more of this when mums who have young children start working. Maybe like they do here, although there are no day care facilities, government-run like there are here. ......But I would have lived exactly the same way in England.... but I've stuck to my guns, without saying anything. You have to accept that not everyone is the same.” (Susan)
“In England, things are starting to change a bit now so that more and more mums are returning to work, although you don't have any of these government day care centres and all. But, the norm continues to be that you're home. That's the way it is. It's the other way around here, with people saying, "oh, are you at home?" whereas in England it's the other way around….. In England it's natural to be a mum at home, especially when children aren't old enough for school and maybe until they're teenagers. Until the children can take care of themselves. So that they can have their own key….. they have to have a key, because otherwise you can't do it. There are children in my daughter's class, who were in the first class who can barely reach the lock and have a key. I think it's horrible, but you can't say anything.” (Jane)

“It just doesn't suit people, it doesn't suit many people that you're at home. You get these strange comments. What did they mean then? Things like that. It's annoying. But I think that it's ...I don't worry about it.” (Jane)

“In England, to work and to have children is not the same as in Sweden. It’s much more difficult. So I was a housewife at home, and you know... I wasn’t leaving a wonderful career anywhere, then it would have been a problem, but it was easy for me to go.” (Elizabeth)

“My fiancé, he wants me to be a stay-at-home mum…. Maybe it sounds strange, but I think it would be so nice to take care of the children and the house and cook and not feel any "musts" in any way....... Quiet days and ...I feel that I want to go back to my own ... I grew up in the country in England, and I feel that I want that quiet again. And my children too.” (Mary)

Migration also had an impact on the way men perceived their masculinity and role in the domestic sphere. This man from Britain felt he had benefited from adopting a more ‘Swedish’ approach to masculinity and fathering:

“I have absorbed a lot from Swedish society, Swedish culture and the Swedish way of looking at things, and also Swedish politics. I think that I, even if I'm far too English in many ways, believe in equality in quite a different way than I did when I was in England…..I have learned to deal with the man's role in quite another way, even if there's still a long way to go. But for me now it would feel like a catastrophe not to be 100% sharing in the children's upbringing, to be there when they are born, to share the responsibility for food, shopping, ironing and all that which wasn't at all natural when I left my own country. I have learned to be extremely positive to much that I have learned here. Above all the Swedish way of solving conflict through discussion rather than aggression. I am still too aggressive, maybe it's part of the English culture, not that all English men are aggressive, I am aggressive and I am aware of it. The way of solving conflict without aggression has given me such a lot….. it's given me a relationship with my children which I may never have had in my own country. It's given me a natural feeling to share responsibility with my wife in many other areas ... it may have been the same in England ... its very possible it would have been more limited.” (Richard)

The British women in Sweden have been able to exercise choice in how their children have been cared for, however, a Bosnian woman in Sweden was not able to exercise
this choice due to her status as unemployed (along with her husband). She was denied the choice to care for her young child at home, and was forced into the labour market to carry out a menial job, whereas, if she had lived by her own norms, she would have stayed at home to care for her young child:

“He was eighteen months. First I asked them at the employment agency if he could be with me until he was two years old and every time they said "OK OK" but after two or three days they sent a letter, that happened three or four times. They said they had to do that, so I got a job as a cleaner.” (Zlata)

In this way, the official integration programme had overridden the parenting choices of this family.

Comprehensive childcare provision is an extremely important means by which women can actively participate in the labour market. Provision in Sweden is, by international standards, excellent and effectively removes barriers to women’s participation. However, pre-school and after school child care in Britain is not something which falls within the jurisdiction of the state, and this can hamper the ability of some families to achieve the level of labour market participation they would like, as this British woman experienced before moving to Sweden reported:

“I did, but a part-time job and nothing at the sort of level that I was really educated for. It was the only job I could do, that fitted in with the children. And it’s like that for a lot of women in England, because child-care facilities are so bad. You can only do part-time, and the part-time jobs are poorly paid.” (Elizabeth)

Similarly this Italian woman was dismayed by the poor level of childcare provision in Britain:

“I never realised that having a baby is going to be an incredibly expensive issue. I just realised these amazing things, like maternity leave is much shorter here than in Italy, there is no paternity leave, there is no primary school paid until about the age of five. The state doesn’t provide. Just things that I think are amazing, that I find really bizarre. (So in Italy it would be different?) Yes, I mean, I would have had a year’s leave as opposed to 18 weeks. 18 weeks paid leave, and you can go up to 29, but they are unpaid, which is a bit of a joke, I think. And the man has got ten days unpaid. In Italy you’ve got the same as the woman, I think. It’s just bad. And also, nursery schools in Italy are run by the state. All the schools are run throughout by the state, so I never thought that there would be an issue about paying for care to the extent in which most people I know pay basically all of their salary – one person. I think it’s just amazing.” (Elena)

This Polish woman also lamented the lack of state childcare provision in Britain:

“It would be nice to have two proper incomes, but then, as I said, in this country having children is a problem in a way because there is no security. There is no kinder gartens, there is no …. Either you have a nanny or au pair, but in our situation au pair is not possible, because we have only two bedrooms. So we decided I will stay with her until she is ready to go to school. We’re managing, it’s fine. My husband is a professional, so it’s OK with one income.” (Irena)
Interviewees reported that in Poland, the role of wives and mothers is very centred around the domestic sphere, and that women are primarily perceived as homemakers:

“Of course. Yes, because Polish girls are very family-like, and they create a fantastic atmosphere, and they economise, which the English don’t……. So the Polish lady, when she takes the reign, you know, everything is OK and it's plain sailing. (So you're not interested in working until your children have grown up?) I think so. I have to look after them….. I'm also this minister of health. A domestic engineer and a minister of health as well.” (Buba)

This works well for some women, though there is a clear class dimension to the way women’s roles are constructed in Polish society. The role of the female homemaker is largely dependent on a highly paid male breadwinner, and in cases where there is marital break-up, the loss of this role and the necessity to enter the labour market as an independent wage-earner without qualifications can be extremely stressful and can have negative health repercussions. However, respondents reported that although stressful, this life event stimulated career development and retraining:

“But I think it was only when my marriage was breaking up, and I knew that working as a waitress I would not be able to provide a decent life for my children. But somehow, deep down, I knew that I had abilities to do better in life than being a waitress. I think that partly I'd settled for this career for my husband was in the catering business as well, although in a higher position. …..And then I had this married life, where I was working in restaurants, and then I had children, so I had a long break. And then marriage breaking up, and then I thought that, yes, this is the time where I really need to pull myself together.” (Basia)

“(Did moving here cause you any stress?) Later yes. It’s more to do with that I’m on my own with two girls…. Well, maybe some stress, because this is, as I said, not my country. I would say that stress is just to do with my family situation. (Do you think the stress makes you ill at all?) Oh, yes….. I’ve got problems with a nodule, with my thyroid, so obviously the more stress I have it affects my thyroid, and that affects my hormone level. I can feel sometimes I’m so nervous, and sometimes when I get up in the morning I’ll think ‘How will I cope, what will I do?’ So this is because of upset nerves.” (Veronika)
Given the overwhelming significance of family migration, it is important that any future project in this area should frame the research within a family context, and consider the role of women’s health both within the domestic sphere and in relation to the labour market. There is little evidence from the interviews to suggest that there are any specific health problems associated with the role of ‘domestic engineer’, so in fact, this could be viewed as a relatively safe and healthy work environment. However, when women cannot make the choices they wish due to childcare or financial constraints, their careers often suffer, and they may end up in jobs which do not reflect their abilities, or which are centred around the children’s needs rather than their own career development. This can have negative health impacts in that such work may be poorly paid, exploitive or stressful.

**Deskilling and health**

Deskilling is a process where skills and qualifications gained through earlier training and employment are either not used or recognised after migration, resulting in downward occupational mobility and potential loss of skills. This process is frequently associated with forced migration, where sudden flight can disrupt an established career path and institutional, language and other barriers after migration can prevent the re-establishment of a career. Deskilling can also occur when migration is voluntary, where there may be a conscious decision to pursue less skilled employment, for reasons such as differential wage levels in sender and receiver societies or for personal and family reasons. Re-establishment of a career after forced migration, in particular, often involves lengthy language retraining, a process which leaves people disconnected from new developments within their professions, with subsequent difficulties in securing employment.

Deskilling is one important aspect of material disadvantage which is often experienced after forced migration. However, it is not limited to forced migrants. The interviews have established that the overwhelming majority of non-political migration is related to marriage and family networks. Marriage partners often face problems in adapting to new labour market demands if their careers have taken a secondary role to family priorities, however, this deskilling is less problematic than that experienced by forced migrants, as there is a voluntary element in the process. Some problems related to deskilling among family migrants were reported in the interviews:

“In Poland, I worked in.......it’s like a local authority here in Sweden. In like a reception .... took phone calls and people who come to see someone...I liked it a lot. Oh, how I longed to return to Poland when I didn’t get a job like in Sweden.... just cleaning!” (Renata)

“It was much harder. The status was much lower of the job itself. It was really hard. I think in terms of relationships with bosses it was different as well, because in Poland I felt I had rights and, you know, I was entitled to a lot of things. And when I came here I felt I had to work, I didn’t feel that I could ask for anything, raised salary, or about conditions. I didn’t really think that I could do that.” (Basia)

“To get back to the level I was at in England back in '88, '98 ... twelve, thirteen years ago ... it's taken me thirteen years to climb back up to get it.... between ten and fifteen years to get back to the professional level, so to speak, that I was at in my native country.” (John)
“But one thing you can say when you move abroad. The demands are much greater. You have to lower that bar, and I have a hard time with that.” (Mary)

“I mean, here in Sweden, you have to have an education for anything, right? … I saw that with my training in construction that I got in England ... the construction business in England ... it didn't apply here in Sweden. So I tried to get into the construction business, at the start, I tried, but it wasn't what I wanted… I tried to continue with my job, but it didn't work out. …..So I'd studied five years so I had one of those diplomas, and was supposed to begin ... specialise in architecture and costs and ... but when I got to Sweden I first had to go and take the university exam and then elementary ... and take lots of tests and go back to school almost back to the beginning, and I didn't feel like doing that. …… It was annoying. Really annoying. That's why I studied so much in England as I was aware that my back and my shoulders wouldn't last. I would be completely washed up by the time I was 40, I think, if I continue, so I have to study and reach a higher level and I had just started to reach there in England, and then I moved here. And then I thought that it wasn't so hard to just continue, but when I started to check it out... I had to go back to school, maybe do three years of adult education and take a lot of tests.... it was hard. I'd just done five years of school and I didn't want to continue and do another five years.” (Stephen)

All of the above cases were reported in Sweden where there seemed to be greater obstacles to continuing careers after migration than in the other countries in the study. However, although the impacts of deskilling can be negative for individuals, with family migration, the wider impacts are often cushioned by support from other family members.

The effects of deskilling on forced migrants are more severe, and are linked to health in a more direct way. The factors involved in desckilling often interact in a complex manner, and can be difficult to disentangle. The relationship between political migration and downward social mobility has been documented in previous research (Al-Rasheed, 1992; Wren, 1999), and is particularly severe among refugees. Contrary to popular conceptions, political migrants are often highly skilled (Busby et al., 1998; Knocke, 2000). The literature reveals variations by country in the way deskilling occurs, and there is significant evidence that in Denmark and Sweden the problem is particularly severe, an argument supported by the fact that these countries have the highest levels of ethnic minority unemployment in Europe (Hjarnø, 1991; Schierup, 1992; Pred, 1998; Ekberg and Ohlson, 2000). In Southern Europe, where welfare systems are not always available for refugees, skilled refugees are forced, along with other (often illegal) migrants, into low paid and potentially physically demanding illegal employment (European Network on Integration of Refugees, 1998; ECRE Task Force, 1999), a situation which is also increasingly occurring in Britain. Paradoxically, at a time when several European countries are recruiting skilled workers from abroad in a number of professions including IT, medicine and nursing, many refugees resident in these countries already posses the relevant skills and qualifications. They may be dedicated to these professions, but a complex set of institutional and cultural barriers may prevent them from re-entering work at an appropriate level.

The effects of deskilling among refugees can include low levels of labour market participation and welfare dependency, which can lead to long-term social exclusion and poverty, factors often associated with poor mental and physical health. This is
compounded by prior experiences of trauma and loss, which affect many refugees. Many studies have documented poorer health, particularly mental health, among refugee groups (Sundquist, 1995; Sundquist et al, 1998; European Network on Integration of Refugees, 1998; Apitzsch and Ramoskruggiero, 1994). Problems can range from PTSD to more physical problems related to the effects of assault, torture or incarceration, or more often, a combination of both. The relationship between deskilling and poor mental and physical health is not a simple case of cause and effect. Instead it is a complex interaction between structure and agency, where institutional factors which impede retraining and employment (these include racism, discrimination, institutional / financial barriers to employment and relevant retraining courses etc.) interact with prior health problems (associated with the trauma of forced migration and potential torture / witnessing of genocide / murder, loss of relatives and home etc.). Thus poor mental and physical health may constitute a significant barrier to effective retraining and employment, while deskilling itself may influence mental health outcomes. The relationship between deskilling and mental health is therefore complex, and often circular (Fig.7).

Figure 7 is inevitably an over-simplification of this complex set of processes. There are other intermediary factors associated with migration and deskilling which have important health implications. Working conditions, particularly where migrants are working in dangerous and/or illegal employment sectors, have important health effects. Access to, and use of, health care, as well as health-related behaviour, may vary by culture and by destination country. The negative health effects of deskilling can be offset by the support of social networks and informal health care, but these will also vary between different ethnic groups, and across nations.
Potential pre-migration problems
Political oppression, torture, incarceration, trauma, bereavement etc.

Potential post-migration problems
Cultural loss, unfulfilled expectations, family separation etc.

Figure 7. A simplified representation of some of the complex relationships between migration, deskilling and health

The situation of the Bosnian migrants in the study revealed some interesting differences by country. Although ethnic minority unemployment in Sweden is very high by European standards, in the study, the Bosnians in Sweden were managing to find work. People with blue-collar qualifications had relatively few difficulties in securing employment of an equivalent standard after migration, but highly qualified people had much greater difficulty. These Bosnians, reflected on the problems their community had faced in Sweden:

“There aren't many who have been able to work with the things they are qualified for and there aren't so many who .. if they were employed in good jobs down there, there aren't many who have managed to get up to the same level again.” (Cazim)
“No, it's difficult to find jobs here. It was difficult but not any more. A lot of them have got jobs now, after eight or nine years. (Most of the people you know have got jobs?) All of them …. the people we know they've all got jobs. But not all of them have got ...the same job they had in Bosnia. The people we know ... who have jobs, one worked at the Bosnian court, but now in a delicatessen.” (Zaim)

“Let's say that we Bosnians have organised our lives in Sweden rather well. And we take the work that's going. If you refuse work, then you end up unemployed, if you want to be a doctor or something here. I mean, but most people I've talked to, everyone in my family is a cashier up there.” (Sabine)

However, Bosnians in Sweden who wanted to continue with skilled careers had faced much greater difficulties. One common complaint in both Sweden and Italy was non-recognition of qualifications from abroad:

“The plans I had then...or all of us who came here or went to other countries, from another life where we sat and studied and made plans for the future ...we all thought we would continue ... or translate our diplomas and qualifications, or have them evaluated here in Sweden, but it turned out that Sweden doesn't recognise qualifications from abroad as being equal to Swedish ones. So we would have had to repeat e.g. three years ... six terms, and it didn't appeal in fact. And so we... some of us ... some people I know did it but others chose to... (What do you think about the fact that, it wasn't possible to translate?) I think it's... personally I didn't really suffer from it in fact. If they choose to repeat the three years they soon catch up, so ... but the country and the system are the losers. They lose a lot of clever and knowledgeable people who are demoted in that way. (How could this problem be solved do you think?) Find out more about their education and give it the right evaluation... I was able to talk to people at the university about my own educational qualifications and they are the ones responsible for educating people here, they understand that I am very well qualified. But the bureaucrats have made the decision that they are not equivalent to Swedish qualifications. It feels somewhat wrong....” (Cazim)

“No I could never get the kind of job I would have had in Bosnia. First of all because my diploma isn't valid here. I actually threw away 8 years at elementary school, 4 years at university, that's 12 years. The faculty, the Faculty of Economics, 4 years university, that's 16 years 17 years, I have thrown away.” (Asim)

“I just think about my sister. She has, in Yugoslavia, worked with... trained as a nurse, but here in Sweden she has worked as a nursing assistant but hasn't received any ... she's had all her papers translated all her diplomas but they haven't re-recognised any of this. I think that's a pity. It's the same with my education in Yugoslavia, it doesn't count that you have trained for something, you have to do it all over again. You could at least go half way so that half of my education could be recognised and after one year or one and a half year's studying I could start doing my job...my sister has worked as a nursing assistant down there for five years and she comes here and people don't believe she can work as a nursing assistant. That she can't put a bandage on, it's humiliating isn't it? That kind of thing makes me a little upset. It isn't that you are putting someone down, it's that she has no credibility, that she can do something of which she is capable. You could do a
practical test to prove you knew your subject… I think that if you have studied for four years in high school or have some kind of university or college degree then you should get some help with what you are trying to do. You shouldn't have to repeat the same course of study and do the same things over and over again, instead you should be able to take something, one and one and a half, two, three years and become what you would have been and what you want to be.” (Sabine)

“I was only angry because I had to study again and re-train, since I had already qualified as a civil economist… And when I was at the interview, my boss was only interested in the qualifications I'd got in Sweden. And that was what got me the job.” (Lela)

The problem of non-recognition of qualifications has affected the Bosnians to a greater extent than the other groups, but the problem is more widespread in Sweden, and has not only been limited to forced migrants. There was also evidence that qualifications even from other EU countries were not being accredited in Sweden and Italy. One of the main sources of employment among the ethnic minorities in many European countries has been self-employment from small businesses. However, in Sweden, even intra-EU migrants have faced insurmountable problems when attempting to start up their own businesses:

“I thought I wanted to work as a photographer, so I went, after that computer course, I went on a start-your-own-company programme and then I saw how hard it was to have your own company in Sweden so I gave that up. (Did you see any difference between having your own company in England and Sweden?) Sure, there are a lot more hassles. A lot more rules and yeah … it was almost impossible for a person who's only been in the country for two years to try to start your own company, with all the papers and jargon and … it was too much.” (Stephen)

The situation in Britain regarding accreditation of qualifications from abroad appeared to be much more favourable. Two Bosnian men reported that their qualifications from Bosnia had been recognised and accredited, which would help them access teaching and university courses:

“It is, but still I have quite a lot of problems to get into course. Because even, even my papers are recognised by British standards, I still need C in English and maths. So I'm sort of trying to get them. Hopefully I might end up next year or the following year in the university.” (Damir)

“(Before you started your university degree here, did you have to do any course to prepare yourself?) No. (They just accepted you because you have the geology qualification?) Yes, I had geology qualification, geological technician, and I have qualification in computing. (So they accepted you for this course very easily, and there were no problems?) No problems.” (Senad)

The interviews suggest that both Italy and Sweden have a relatively poor record of accrediting qualifications from abroad, while in Britain, the situation is better. Some Italian academics actually reported that they preferred to work in Britain as the system of funding and getting jobs is more open to international competition:
“It’s easier to get an academically satisfying job here. It’s more open, academia is more open. At the same time. It’s less connections to get a job, what counts is more your publications, this kind of thing.” (Giovanni)

“I mean, in Italy I could never be an English person, having an academic – very rare, very rare – for an English person to have an academic post in Italy. It’s unknown. It’s very, very insular. Very insular.” (Tina)

In Sweden and Italy it is difficult to have any qualifications from abroad accredited, even from other EU countries. Given the goal of creating greater mobility of labour within an integrated European labour market, this appears regressive and counter-productive if the accreditation of qualifications is not reciprocal. There appear to be few problems for people moving within particular transnational labour markets e.g. within large transnational companies, or within some academic circles and specialised fields, but for migrants who are motivated by family reasons (already established as the majority of intra-EU migrants), or for forced migrants, the non-recognition of qualifications constitutes a real problem.

**The health impacts of deskilling**
There are clear health impacts of deskilling, and in the study, the Bosnians in particular reported difficulties in gaining access to the labour market without long periods of study. Some were rendered welfare clients for the first time in their lives and had difficulty adapting to this:

“The most important thing is to avoid staying at home. Because when you are at home, you start thinking too much about what has happened and you look backwards all the time. Then you just get angry... how shall I put it... start... thinking negative. The most important thing is having something to occupy you. To be very involved in something so that you haven't time to think about all the bad things that happened. Then you can start to think positive.” (Lela)

“I told you in the beginning that it's the biggest problem for us, being unemployed, because we used to work, and we like work, of course. And now it's stopped, and we cannot find any jobs. It's very, very bad, our psychological situation without a job.” (Gaz)

Frequently, it was reported that finding work was instrumental in mitigating some of the worst psychological problems resulting from events in Bosnia:

“When I got a job everything was fine. (What was so difficult before? That you and your husband were both at home all day?) Yes. (Was that when you started having problems?) Yes. We used to scream at each other ... and I got some tablets. I took them often.” (Fatima)

“I liked working with people and I had a job down there which I'm continuing here, so it was good to become part of the work force. To start speaking Swedish, not just sit at home listening to and gazing at the TV and thinking about everything that had happened.” (Sabine)
“First I needed a job in order to feel good. It’s the only way to get over everything that had happened, and in order to feel well I had to have a job. And then when I got the chance to work, when I got a job, since I believed, sub-consciously that if I lose my job, I lose everything. And it was because of that that I forced myself all the time.... It was most important to find something interesting to do and have an occupation. That was what was important. *(What do you think the authorities should do then?)* Keep people occupied and interested. It doesn't really matter what they are doing. In the beginning.... The most important thing is to avoid staying at home. Because when you are at home, you start thinking too much about what has happened and you look backwards all the time. Then you just get angry... how shall I put it... start... thinking negative. Thinking negative. The most important thing is having something to occupy you. To be very involved in something so that you haven't time to think about all the bad things that happened. Then you can start to think positive.” *(Lela)*

The importance of work was highlighted by this Bosnian who had experienced severe mental health problems associated with events experienced in the war. He describes how he copes with the effects:

“It didn’t stop me from getting on, but it actually reduced my ability. I fight it very hard, but it stops you sometimes, it spoils a day sometimes. You feel you just don’t care about anything, you know, sometimes. Sometimes you are not ready to meet your children or wife. But I had tried to..... put this to the side. That’s why I chose to study, first to have better with me but also to have something on the mind. When I have exams, or coursework to do, or I have to listen to lecture, then I have to take care of those. *(So has it got better with time?)* It’s got better, not with time, but because you are more busy. You have less time for this, but sometimes I don’t want to do anything, stand back.... But it’s better if you work. If you work, or you’re studying, or whatever, in life something for the pain. If you haven’t a creative job, or something like that, then it’s very rough.... I make my mind busy, studying or doing something hard, you know. Change something in the house or sometimes just.... You know, it’s like you have to just get down and work hard. *(Senad)*

These extracts suggests that the well-being of refugees is compromised when they are unable to work or participate fully in the society in which they live. The problems resulting from inactivity can often interact with other pre-existing factors. This is also reported by practitioners working in this field, as Summerfield (1999) observes, it is typical for refugees undergoing treatment for mental health problems to express a greater need for help with social and economic factors.

**Trauma as a barrier to employment**

Losi (2000) argues that the Western and biomedical conceptualisation of mind and body dualism separates illness into two distinct categories of organic and psychological disorders. However, he asserts that "most of the world's population experiences suffering as an integrated mind and body reaction, and, for many cultures, a spiritual dimension remains of great importance to the process" *(Losi, 2000:13)* When considering the health problems of refugees, it is therefore important to resist the temptation to channel health problems into a biomedical explanatory framework, as this can sometimes be unhelpful and counterproductive. Trauma may manifest in a
variety of ways both mental and physical. Losi argues that it is not always possible to define a clear set of symptoms which arise from trauma, that people are afflicted in different ways which cannot be defined in strictly scientific terms, and that forms of psychosomatic illness often appear with psychological symptoms. Trauma itself is also a contested term, with no singular definition (Summerfield, 2000), and as a result, it is applied to a wide range of situations (Saul, 2000). Papadopoulos argues that the term ‘trauma’ is a social construction, as it is related to: “the way one construes and experiences a fact rather than the phenomenon itself” (Papadopoulos, 2000:92), so the meaning attached to a traumatic event is important. One set of events can therefore have very different repercussions and meaning for two different people, depending on the ways in which they are rationalised. A political prisoner is therefore likely to suffer less from imprisonment and torture if he/she has a clear committed vision of fighting towards a common goal than e.g. a victim of random violence in a war situation. Sometimes ‘trauma’ is channelled into a single diagnostic category of PTSD, which encompasses mainly psychological disturbances. However, Papadopoulos argues that ‘trauma’ is not always attributable to one event, but to a range of circumstances before and after the perceived event, also including the time immediately after forced flight, when people face a new set of circumstances which often incorporate material disadvantage and problems such as deskilling. It is therefore important to allow a wide interpretation of the health effects of trauma which can encompass both mental and physical symptoms.

Direct experience of violence has varied among interviewees in the pilot study. Some Bosnians did manage to escape the worst effects of the war, while those interviewed in Britain appeared to have suffered the effects more acutely. Some of these people had been formally diagnosed with PTSD, others had not, but for those who had experienced traumatic events in Bosnia, the range of symptoms was much wider than a narrow PTSD diagnosis would suggest, encompassing a range of both mental and physical symptoms as demonstrated below:

“Yes, I've lost five members of my family. My sister, they killed my sister, my sister's husband, my father and two relatives. There's so much you think about. … Sometimes you laugh but you aren't happy. When I'm working and get to work, I cry. But then when I start work I start to laugh … you have to pretend to be happy. I don't want people to see that I have problems. I laugh but I have pain here (holds hand on heart)” (Fatima)

“Always fear, there was always fear. When you hear some steps from stairs, you sit in the bed and ...... there will be somebody who.... There was always, always fear. …..for my age, for my health. I'm a very depressed person. I'm very sad. I couldn't do anything now. I'm not fit for any difficult job. ….. I have problems with my balance, I have vertigo, and was in hospital for a month. It was very bad experience. And now I don't feel very stable and secure, and because of that I couldn't work.” (Almira)

“(Do you think that you've suffered any long-term effects from any of the violence that went on in Bosnia?) Yes, I have a bad back and I have asthma because we slept for seven and a half months on concrete. Also, some mental problems with post-traumatic stress. I'm talking about it because I know lots of people who has lived through the same story, and …..” (Senad)
"When I first came here, first I was very happy that I'm alive, and for a few months I don't think so many things about me. I was just happy here whatever came out because I'm alive, and to feel it what I was needing for that day, food or drink or anything else..... But after that I settled and then came problems with sleeping, I had very bad dreams. Unbelievable horror, waking up frightened and sweating. And some days that put me down, and then more after that ...... I have bad backache, and knees, and asthma. It's probably psychological, but before that I didn't have any other problems. (Do any of these problems affect your ability to work?) Yes. Sometimes if I had a bad backache I couldn't walk at all, and I need some help to get up or sit down. Sometimes, you know, it's quite good, but sometimes it's so bad I need help from somebody. (Have you seen a special doctor about your back?) Yes, but the problem was they couldn't find anything physically, and then my GP said this problem may not be just physical, it could be a mental condition.” (Senad)

“(So all these things that happened to you, has that affected your ability to get on and find work and...?) It definitely does because I mean it, first well we did sort of notice, as soon as we found our way in sort of normal things, other troubles started, like headaches, sort of disgust towards food, or you know, food didn't get well with us. And then, sort of other bits like toothache, backache, pain in joints, you name it, basically, because the thing, was probably the further we probably go from the camp, the more physical trouble we had. And together with that there's also mental sort of, you know, headaches and sort of low esteem. Not low esteem, but a huge depression, you know, and that sort of keeps going, and winding up, because we never were, anyone of us even not today, nine years later, weren't offered any mental health. Now, if you go to your doctor and complain about headache, or anything else, he'll give you painkillers and sleeping pills. That's it. I still have sort of, not sort of, I still have nightmares. I still have sort of low mood or snappy moments. And I still sort of, I mean, whenever I had nightmares, the next day I'm not very good to live with basically. And as you can notice I have a back problem, shoulder problem, knee problem.” (Damir)

Some of the problems outlined above were directly related to incarceration in a concentration camp. Clearly, when suffering from a range of severe problems such as this, there are major difficulties involved in undertaking any work which involves physical activity, as this case demonstrates:

“First it started with my knee, as soon as we arrived. But soon later I noticed that I can't kneel, or I can't neither stretch leg, I mean I can stretch out, my knee is working properly normally, and I can't stand long on my leg. And I can't bend it. If I bend it for long, then it hurts. And then it started with lower back, the next thing that went it was lower back. After that comes shoulder. And then neck. A problem with stiff neck I've got just from last year. I did have one small what they called, observing operation of my knee, about, about three years time. But they said I've got excess or more than I need, tissue in my knee joint. And shoulder problem, it's actually I'm lacking that tissue in joint. (Do they know why it started?) One of the things that they think it's ... In the shoulder they think that I'm lacking it because of the fast loss of weight. And the other, the knee, they think it might be connection to the fast gain of weight. Because you know, when we came, when I came to hospital I was about forty-four kilos. That would be around ninety pounds less.
And then we were putting weight, something like three, three, four pounds a day. And the joints, especially the, the ankles, every evening were swollen. And then during the night they'd go back. And they explained it with what they called, not energy, but what they called calories or you know, the body food was sort of couldn't go that fast into muscle, into, into, so they went into joints, joints are presumably easier to absorb energy or whatever it is. So we had every single night swollen joints. And during the night that goes into the body. So we sort of were, they were sort of pumping us, because our faces from very thin go like that puffish in something like seven days time. (Does this affect your ability to find work?) The thing is some people do manage to work. To be honest I wouldn't be able to let's say work in Tesco, putting on and off shelves. Or I even have trouble, not all the time but like now, and like the last one and a half months, I have trouble sitting. Not to mention sort of bending or doing anything else. So it does have, some people are more affected like in our community there's friends that I know, some people are more affected with mental or physical health, and some people are less...But basically, I mean, it would be very, very hard to find a job, to find an employer who will give you a while sort of off-time.” (Damir)

Not all of the Bosnians experienced the severe symptoms described above. Other experienced a more general sense of anxiety and unease which impeded on their daily lives:

“Yes I have to …. if I'm going to do something plan it in detail. Plus, I am terrified that something will happen to the children, or that they might fall in the park. (Why do you think you have these feelings?) Because of the war. … Yes its really wakened my feelings and then I've seen masses of dead bodies there. And then ... I'm quite certain it's because of the war. I'm afraid that someone will take my children, for example. Sometimes I watch TV programmes like Crimewatch etc, and see that lots of things are happening. And then I start to think, to try to stop the children going out very far, or I'm afraid. I don't know why. .. I'm afraid that ... as I talked about before, of that fear. For the family and everything.” (Faruk)

“(Does it make you feel depressed?) Yes, every day. A lot of killing people in the city, a lot of violence in the city. It was very bad situation… We cannot do a lot of things that we used to do. A lot of tension, but now we are worried a lot about our son, about our lives, about our relatives there. These things worry us every day.” (Gaz)

The effects of the war in Bosnia clearly have had an impact on the ability of the Bosnians in the study to adapt to their new situations and to work. However, it is also clear that the ability and willingness to resist these problems and fight back is also strong, and is helped by accessing employment or retraining as quickly as possible, avoiding long periods of inactivity. Integrated refugee programmes, where the health and retraining aspects are dealt with together, are more likely to be of benefit to displaced people who have experienced trauma in any form. Watters (2001) criticises the tendency to portray refugees as ‘passive victims’, while ignoring their ability to resist and challenge the problems they face. There is a real danger that programmes such as that in Sweden, which portray refugees as passive victims who require all their needs to be catered for by the state, can prevent this resistance from being harnessed. They also remove the potentially supportive role of social networks, which
have proved to be a very important factor in the adaptation process. This, in combination with the problem of non-recognition of qualifications from Bosnia, tends to render refugees as welfare clients, which appears to be very detrimental to their general well-being, and making it much more difficult to overcome problems. Further, when considering the role of mental and physical health with displaced populations, it is useful to remember that in some cultures, the individual perspective does not have primacy, and it is more common for people to perceive themselves as part of a wider set of social and family networks, and it is often within these wider networks that people derive their self-worth (Losi, 2000). Understanding the way that other cultures view health and health care, is an important aspect of refugee care, as it is often within a group framework that healing takes place, e.g. the role of indigenous Buddhist networks in healing among South East Asian refugees in the United States (Canada and Phaobtong, 1992). It is therefore vital that any future project dealing with the issues of deskilling and health should also examine the context within which forced migrants overcome the problems which they have faced, and the methods they use.

However, as demonstrated, deskilling is not a problem exclusive to refugees. Although the complex set of interacting factors associated with deskilling and health is more likely to affect refugees, other migrant groups also suffer, primarily due to an unwillingness among some countries to recognise qualifications from abroad. The study suggests that this is a significant problem in Sweden and Italy, and to a much lesser extent in Britain, where language is less of a barrier and there has been a longer history of employing workers from abroad. Given the current trends towards globalisation, increased labour mobility, and the need for international competitiveness, it appears that this is a problem which needs to be addressed, both to prevent unnecessary social exclusion among migrants, but from the perspective of receiver societies, which are losing out on valuable assets in the form of skilled labour.

**Age related problems**

The issue of age can be viewed from several perspectives. Scott and Bolzman (1999) argue that older refugees and exiles rarely receive much attention in the literature, and as a result, they fail to attract any recognition of their plight. Refugees who are relatively old at the time of flight are likely to experience greater problems in re-establishing their careers, as it is more difficult to retrain. This, combined with generalised age discrimination in the labour market, makes it very difficult for older refugees and migrants to rebuild their lives. Scott (1998) claims that older migrants are less flexible than younger people in adapting to a new life in exile, particularly when they are separated from their ethnic community (Montero, 1979). The Bosnians in the study who had been forced to migrate later on in their lives expressed their concerns:

“I thought, who on earth is going to employ me at the age of almost 50, and an immigrant to boot. I have no value on the market, was how I reasoned. Until there were changes in the firm and since I felt passed over I was slightly irritated ….. I felt that no one wanted me and that made me feel bad.” (Lela)

“I think our age is the worst problem. There are a lot of jobs that, for example, I can do without doing more speaking, but of course, language is very important. But I think that our age is a very big barrier to start it off.” (Gaz)
There are also issues related to health which should be considered with older migrants in that they are more likely to already suffer from health problems before migrating:

“I suffer also from rheumatism and arthritis. My fingers are bad. (So you had lots of problems before you came here?) Yes, and now I was afraid of everything.” (Amira)

The problems described above are related to migration in later in life, however, there is also growing evidence that becoming old in exile also carries a set of problems. Some cultures value the aged less than others, and where people migrate to countries where they are not valued as older people, the loss of status can have a detrimental psychological impact (Scott 1998). This, along with the stress of being uprooted can lower the quality of life, often leading to poor physical and mental health (Scott, 1998). There is considerable evidence that traumas experienced in young adulthood can re-emerge in later life, manifesting as anxiety, depression, neurosis and paranoia (Scott, 1998). Mental illness is now one of the most frequently reported health conditions among older refugees and exiles (Scott, 1998). The Poles who arrived in Britain after World War 2 experienced many atrocities during the war, and they are believed to be the largest surviving group of older refugees and exiles in Britain. The high levels of mental health problems among this group should be viewed as an indicator of the types of problems that current refugee groups in Europe may experience in future decades as they age. In particular, the ‘Polish disease’ (Scott and Bolzman, 1999) of paranoia appears to be a common reaction to suffering and trauma more than half a century ago. The health care needs of this group clearly need acknowledgement and attention as a specific and distinct category.

**Migration and work-related health problems**

One of the major issues of concern in this pilot study has been to examine the way that changes in occupation can have detrimental health effects by exposing people to health risks in the workplace which they are unaccustomed to. These problems are often closely related to deskilling, where people are taking on less skilled and more physically demanding work. Musculoskeletal problems were one of the main issues raised, and typically it was the Bosnians in all three countries who reported the worst musculoskeletal problems related to work, as they were more likely to be working in new types of occupations:

“(But these problems with your neck and back, did you have them in Bosnia, or did they start when you came to Sweden?) When I came to Sweden. I also did cleaning and it was the cleaning job that caused the problems…If you work in the wrong way, if you don't do the jobs right you can get neck problems…Plus that we had to work so quickly ... to get the job done in time. (Had you had any training at that time?) No nothing. (Do you think that was why you had problems, working in the wrong way?) Yes, I think so.” (Faruk)

“No, but physical, if you say that, injuries when you work eight, nine and ten hours. It isn't an easy job, cleaning I mean. There's quite a bit of lifting... (Have you sustained these injuries since you started your company, or did you get them earlier?) Earlier, when I was a caretaker. And that job also involved cleaning tasks.” (Faruk)
“(Did you have any training for the cleaning job?) No. It was hard work and stressful. I have a problem with my back and ... I have papers to prove it's sciatica in fact...I've never had a back problem before. (Did you get it through working as a cleaner?) Yes. (And you hadn't received any training in how to move or ...) No, nothing. And there was a lot of work.” (Zlata)

However, it is not only physically demanding work which can lead to health problems. People working in the IT sector have also reported problems related to their work:

“(I noticed that you said you had some problems with pains in arm and hand. Is that because of work?) Yes. (You didn’t have any problem like that before?) No, I did use a computer in what I did, but not with the mouse, that was just the keyboard. Its stressful ... the job is stressful in that we’re under pressure to fulfil requests from customers. Do this, do this, do this, do this...like that, so... So that’s the pressure, you see...... I’m sure it’s affecting my health, because I know I’m like this and look at the screen intently and I concentrate very hard and I’m not sitting properly. I know I’m sitting rigidly, like this...... I’m very aware that the sort of job I’m doing is damaging my health. Because I led a very healthy life when I was this housewife at home, and I would walk around Stockholm a lot and do a lot of walking, and be out in the air. And now I’m very aware I’m in a small room in an office and there’s nothing to see out of the window but another wall and there’s a screen in front of my face. So, physically ...I’ve put on more weight and I feel I’m not as fit. I do less walking and mentally I feel it will tell on me.” (Elizabeth)

“I had to start wearing glasses because of the problem with the screen. There’s no proof, but I had a very good eye-sight and then it deteriorated. It’s got slowly worse.” (Jane)

Work-related health risks

There were a range of work-related health risks reported in the study, and the worst of these were associated with illegal working. This appears to be particularly widespread in Italy, where even migrants from Sweden reported working illegally. One of the problematic issues raised in Italy was the occurrence of accidents in the workplace. Accidents which occur when people are not working legally, leave workers with no insurance or rights to compensation. Also, they are not covered by legislation relating to safety in workplaces and may be exposed to unnecessary dangers in the workplace. However, other risks occurred quite legally within normal working situations, and seemed related to particular occupations. Some people working as cleaners reported risks to their health:

“(Do you feel as though your work situation is in any way harmful to your health, the way you work today?) A little maybe, with all the chemicals. They are very strong, they could be harmful, but sometimes you have to use them to get rid of stubborn stains. And then there's the dust. That could also make for a hazardous working environment.”(Faruk)

“No, but if you ... sometimes they are so strong you get a headache or you feel them in your nose and eyes. (So you got headaches when you breathed in the
Building was another occupation which was reported to carry health risks, and these risks are much greater for migrants, as the following account demonstrates:

“I’m quite aware of the dangers on the building site… because you have to …when you’re doing prices you have to quote less, and less means less safety. There’s a lot of things like asbestos which can cause harm, you know, cancer….. If the employers are aware that there is something there then you know they will joke about taking the roof down cheaply - no problem with the asbestos to be removed by a specialised firm – just get a few Poles to do it. It does happen a lot, but you know just like, one thing stands out…You have to be aware of those dangers you know, the dangers become part of the job you know. You have to watch out for that. (I mean how can it happen? Use people to take asbestos out of buildings….. ) You know, all the time, although they……these you know like may not be asbestos 100%, but it’s just you know, asbestos and other things. Roof houses, and also you know these ….they have a way of getting people to check for asbestos. You never know if it’s asbestos or not, and if it is then you have to get a special firm, you can’t just do it. If someone’s had a house, they don’t want to spend money on a house. If you were renovating a house and had a whole roof of asbestos, you don’t want to go to the specialist just to make sure that the people who are working there don’t get sick….. You have to be…..you have to watch out for yourself you know. You have to watch out for the sort of dangers. …..if you don’t have any common sense you will get hurt, but you know …. I would like to think of myself as having a lot of common sense, you know. I see the things before they happen.” (Heinz)

Comparative health risks
There is also evidence that work-related health risks vary considerably by country. Work-related health risks occur everywhere, but most of the dangerous conditions were reported either in illegal working situations or in Britain or Italy. Safety in the workplace appeared to be more regulated in Sweden, where comprehensive legislation protects workers from most types of risks. The following typical account compares safety in the building trade in Britain and Sweden:

“No, it's a lot more dangerous in England. There are no rules there. It's good here in Sweden, you've protected quite a lot of things with there being so many rules….. but everything's just about money and being fast (in England).. if you're going to build a house you ... yeah, you can't afford to set up real scaffolding, or hire a crane or something, so you hang from the roof or do dangerous things, so you save money, you do. But here, you can't do that.” (Stephen)

“I'm from the working class (in Britain), and it's all work and wearing yourself out and then you don't feel well. Pain in your back and your shoulders, and there's no one to help you, instead you have to help yourself. If you're unemployed, there's no money ... there's nothing. There's nothing like the unemployment benefit fund, where you're protected for maybe two years and have the chance to find a new job, there isn't that. And during Margaret Thatcher's era, it was hard, because it was just high unemployment and you had to work hard to keep those jobs. So I think, like I
said before, there were dangerous jobs and you had to try to offer a good price quote, you know, if you want the job. Otherwise, someone else gets it who's cheaper. There is a difference in fact ...I notice that when I go back, when you've lived here, it feels very ... you see this difference between my friends who are wearing themselves out for a thousand crowns a week or something and everything costs so much. It's not cheap in England.” (Stephen)

**Occupational health services**

The role of occupational health services is an important element in the protection of workers in the workplace. Interviewees were asked about the occupational health services associated with their work. Interviewees in Sweden were very well informed about these services, and many had been offered health checks:

“Yes. But...if I had the same job in England, the same job, I wonder whether the office conditions would be of such a high standard? Because I’m very aware, in Sweden, in all matters environmentally... and you mentioned the unions...Swedes are very conscious of the health of people and the way they work, and all these things. So I feel that everything...more is being done here that it could be... than it would have been done in England.” (Elizabeth)

“I think we’ve been very lucky because I think ... Swedes in general take care of themselves a lot better than probably anyone else in Europe. So, putting that with a company like Ericsson, who care about their employees... They supply them with social events, you know, sports, you know they’ve just built a swimming-pool, they really care. You add these few together, then Sweden’s probably the ... in my eyes one of the best places, you know, for a healthy work. … I think that’s very special and unique. And I don’t think you'll find that in many European places. But I mean, in Ireland they never think about their health. I worked in two different companies in Ireland, with terrible work conditions. So for me to come from there to here was … You know, it was fantastic. I would say only positive things about Sweden and work health. Because of the culture.” (Jane)

While some interviewees in Britain reported that they were aware of occupational health services, there appeared to be less emphasis on safety in the workplace, and less awareness of the existence of occupational health services. Some people working in sectors where occupational health care is provided (e.g. academia) were unaware of its existence and did not know where to go for help. Most skilled workers had access to occupational health care and were insured for work-related accidents, but people working in manual sectors such as the building trade had to work without insurance cover or provide their own. In Italy, the situation was more variable, with some workers having cover and others not.

Overall, the quality of occupational health care and safety in the workplace appeared to be far better in Sweden than in either Britain or Italy.

**The role of trade unions**

The trade unions in all countries have had an extremely important role in striving for safe and healthy workplaces. It was hoped in this study to evaluate how effective interviewees felt that the trade unions had been generally, but also in specific cases where people had sought help or advice. As part of the interview process, all respondents were asked about trade union membership and about any direct
experiences they had had with their relevant trade unions. The responses were rather disappointing and did not elucidate many issues related to the trade unions. In Sweden, where trade union membership is relatively common, there was considerable feedback, but in both Britain and Italy, only one respondent in each country were trade union members, so it was not really possible to evaluate the role played by trade unions in these countries.

In Sweden, the trade union membership level was high, indicating that the trade unions in Sweden have been very successful in recruiting members from the migrant populations. However, the expectations which most of the union members had of the trade unions were not met. It is difficult to gauge whether these expectations were unrealistic, but the number of criticisms seems to reflect a problem in this area. There was a significant number of complaints associated with direct personal experience of the trade unions, or with reports from other people who had been dissatisfied in some way. Some of the following extracts demonstrate the nature of these problems:

“Yes, the Swedish Municipal Workers Union. (Have you ever needed to contact them about anything?) No. I haven't called to talk to them but I don't think they do such a lot..... Yes, I've heard that, that when you need them they aren't much help.” (Sabine)

“LO, the Hotel and Restaurant Union. I recently got in touch with them... wanted some advice .... because I have to change jobs because of the injury to my arm. But I was incredibly disappointed and surprised. Boy, I was treated badly. The woman, who was in charge of the area in Lund was downright impertinent and unpleasant. I’ve never been treated so badly since I came to Sweden.... and it’s my own union! I had to appeal to the head of the Skåne Region.” (Jozef)

“(Are you a member of a trade union?) Not anymore. (What made you decide not to be a member anymore?) Well, I was made redundant and went to the union and they said "go to hell" more or less. (Did they have any special reasons?) No, they didn't say so, but they say “Sorry, that's life and we go by the rules and so it's last in, first out and you're one of the 40 that have to go. Sorry, that's the way it is and you're no exception.” I myself thought I was an exception because I was the only one managing the machinery stock I was working with. ..... No, but they're not interested. I don't think so. I've never met a union member in Sweden or abroad who has ...yeah, said something that people think is good. It's all a bluff, you know. I think so. I think it's a bluff.” (John)

A Bosnian man had contacted his union regarding difficult working conditions:

“(Did you get any help from them?) No much actually. I don’t know, it was difficult to get hold of them when I needed them, to find someone to talk to. They have different opening times ... two days a week ... I don’t know. And then it was impossible to get any help. And it was stressful. I was, you know, you could say helpless. I had the choice between working and resigning. I didn’t feel there was anyone who could help me. I tried to get help... I tried to discuss the situation with someone. With my employer mainly, but it didn’t work.” (Faruk)

Concerns were also expressed over the cost of union membership, and some people reported that they had not joined unions because they could not afford to.
In Britain, there were some clues as to the low rate of trade union membership. Some people expressed a desire to join a trade union, but had ‘never got round to it’, and others were not in a position where they were able to join a trade union, as their employers would not permit this. Most people were fairly positive about joining a trade union, and would probably respond well to some extra encouragement. It would appear that perhaps the trade unions could become more active in their efforts to approach workers and inform them of the roles and activities of trade unions. However, some stereotypical views of the trade unions held by migrants who left Britain for Sweden indicate that there are certain negative views about trade unions in Britain which may partially explain the low levels of membership:

“In England, if you’re a skilled person, so you’re a graduate, you don’t tend to join a union. You kind of link unions with coal miners or people like that. But of course there are unions for everybody, but you feel that if you’re of a certain education you can probably manage things yourself and you don’t need a union.” (Elizabeth)

“(Are you a member in a union?) No. (Is that on purpose or are there any special reasons?) It’s on purpose. Things feel secure at my job and I also have good relations with my employer. I can always talk to them and they’ve always supported … (When you lived in England and worked there …) There was no union, because it's not good being in a union in England….. Things don't work…… and you know in England they’re always going on strike.” (Stephen)

Racism and discrimination
All interviewees were asked of any experiences they may have had of discrimination in any form after migration. As all of the migrants were white Europeans, they had not experienced racism in the same ways as many other ethnic minority groups, and some even reported positive discrimination. However, there were certain issues related to discrimination which have emerged as important.

Swedish migrants in Italy generally reported positive discrimination both within and outwith the labour market because of a very positive view of Swedes in Italy. However, Poles and Bosnians identified a feeling of mistrust directed towards them, and an unwillingness to employ them, particularly in the early stages when their Italian language skills were not very well developed. Most reported that the situation improved with time.

In Britain, one Pole had experienced positive discrimination in acquiring a job because of his Polish background. However, negative discrimination was more common. The Bosnians experienced the worst discrimination of the three groups in Britain.

In Sweden, the British migrants did not report any discrimination, although the Poles and to a greater extent the Bosnians did. They did not report experiencing direct hostility, but felt they had been discriminated against in the job application process:

“(Have you ever … when you have been for job interviews, felt that you've had … that it's been a disadvantage that you are not a native Swede? Have you felt discriminated against?) Yes, sometimes, actually. When I apply … now when I’m applying for a job. The things I deal with … my job is in a rather important part of the IT branch. There aren’t so many people in Sweden dealing with this. And when you see an advertisement asking for just the skills you have… you know you are well qualified for the job…… my area needs someone with specialist knowledge.
So I have applied for new jobs several times lately and you notice that some companies, who are a bit more ...conventional like, they are a bit old-fashioned. Sometimes you don’t even get an acknowledgement of your application, even when you know you have the specialist knowledge they are seeking. So you can wonder what the reason is. I know they can’t have got so many applications that they haven’t had time to reply. They have probably got two or three. Maybe mine is the only one since it is ... there are very few of us who have no occupation. We are all employed. So you really wonder what the reason can be. I’m convinced the reason is my name...... in such situations you feel that something is not quite right....... I’ve had the feeling quite often. And it always seems to be banks or small consultancies in the middle of Stockholm. It’s always such rather unusual places. If it’s a place where people work in an ordinary way and it doesn’t matter what you look like ... then it’s fine.” (Cazim)

“If you talk to them everything is OK and then they ask what's your name? When you tell them they are afraid. They say, “Yes, there may be a job ....” and when you say your name “OK, we'll see, I'm not sure”. I know it isn’t easy. They are afraid. It isn’t easy. (Even though you speak fluent Swedish?) Yes. And when he says “What's your name” they say “aah, I think...I'll call you back”. (Fatima)

“When I was at the employment agency “Oh, you're a muslim?” ....you have to go there in person so they can see what you look like otherwise they expect you to be wearing a veil. He said it kindly but it didn't feel good.” (Lela)

This perceived discrimination, in combination with the problems of non-recognition of qualifications from abroad, is an important component in the deskilling process, constituting an extra barrier to the labour market. When these problems are considered in combination, the Bosnians (along with other refugee groups) in Sweden clearly face very significant institutional barriers to full participation in Swedish society. This was a confusing situations for migrants, who had difficulty accepting the incongruous way they were dealt with in Sweden:

“Oh, this two-sidedness in Sweden. It’s hard for immigrants to figure it out. It’s like it’s a bit crazy. It’s one thing how the authorities behave towards immigrants and...a completely different thing how people behave.... The government is very open and positive to immigration, but not all Swedes think like that....MANY people don’t think so. There’s a double message. First...before you come here, everything’s all positive and nice...and then when you get here it, you get a big bang in the head from people...they don’t like it that you come here....I don’t experience this so often but many other people feel a kind of racism towards them. There are Swedish gangs formed against foreign gangs...they don’t want to mix. It’s deep down in people’s mentality ....not accepting foreigners. I certainly don’t want to accuse Sweden of being the worst.... but I think it’s a little of this Scandinavian mentality. No offence intended, but I think that it’s because of the country’s geographical location.....like on the fringe of things. But the way immigrants are treated ...it’s not the country’s or the government’s fault. It’s the fault of some people.” (Jozef)

This aspect of discrimination is less evident in Britain, where there has been a relatively long history of employing skilled workers from abroad. However, the
reports in Britain were more likely to be related to incidents of overt violence, such as the experiences of this Bosnian woman in London:

“When we came (to London) we, they put us in a place where all the English people live there. We had lots of problems, I couldn’t get out. I stopped going to, to bring my daughters to school. And they used to throw tomatoes from windows on my car, they opened by knife my car. After that, they saw me in the underground station near my house, the same people, and then they tripped me up on my scarf and started spitting. It was a group of maybe six, seven of them together. And saying bad things. (So it was the same group of people all the time who a harassed you?) Yeah... And police met them. I reported them three times but they never stopped them. They know them…… I just, I know the police know them, that group. (So how long did all that harassment last?) Two years. (Two years, and they didn’t stop them?) Nobody did stop them. And they just forced me to get out of that area. I reported to the police then they started to do lots. I thought maybe they will stop. But they made it worse.” (Farida)

And this Italian woman, whose husband experienced a violent attack:

“We had a racist attack, unfortunately…my husband is Italian and the night of the World Cup they thought that we were French. We were a group Italians, we were chatting, and they attacked us, basically, which had a tremendous physical impact, because Marco had to undergo surgery, and I reacted very bravely and I think that maybe somehow it got into my system and maybe I was sad afterwards.” (Theresa)

Others reported less overt discrimination in Britain:

“I must say that there is a diffused sense of suspicion towards Italians, I must say. The people we see, who are British, apart from the people I work with, are very kind of nice and colleagues of my husband, so no, not from that. But, I feel a sense of racism which is towards foreigners in general when I read certain kinds of papers, tabloids and so, yes. If I happen to be on the tube in morning and going to work and I catch just a line against foreigners on a tabloid I feel immediately discriminated against.” (Theresa)

 Discrimination also manifest through differential wage levels, as this Pole working in Britain explained:

“When I was working in a restaurant for a Jewish man he was constantly going on about “Oh you Polish. Poles this, Poles that” and he was taking the mickey out of us like what was very extortionate like paying wages like he did. Basically it’s money. Discrimination is in the money. (Do you find that in your building job?) Yes definitely. (How do they work that…… how do they pay you less?) Because they don’t have to pay taxes for you, you don’t have to pay taxes, and obviously I didn’t have a permit to work. I don’t have permit to work. There are other people who don’t have a permit….. so you see if you want to go and work you won’t get the same money. If an English man earns £12 an hour working on a building site, chances are the Polish man £5 or £6. That’s a lot less ….. So that’s one way to discriminate people. But there’s a market for illegal workforce. There is a lot of it.” (Heinz)
This was confirmed by other Poles who had worked in Britain illegally:

“When you start to work here, yes! You don’t speak nothing so you just work for nothing. For £100, £150 a week. So it’s nothing. Language, visa. I can work better now. I speak a bit of English, and got a permit to work so I had more money. (Did you not have that at the beginning?) No. (So then they gave you much less money?) Yes. (Andrzej)

“At work, in a sense that when I worked for the first time in England in ’79, I had no rights, because I was illegal immigrant in a way. I stayed for a year. I had no rights. I used to work so many hours and being paid very, very little. When I met my future husband we worked in the same restaurant, and I remember I was getting £40 a week in 1979, and I was working for 12 hours a day. And he was earning £40 a night, and he was only working for seven hours.” (Basia)

*The Romani people*

The most severe discrimination was identified in Italy against the Roma people. A number of the Bosnians interviewed in Italy were of Roma origin. The Roma people constitute a special case, and given that around 10% of the Bosnian population were estimated to be of Roma origin in the last Bosnian census (pers. com. UK Bosnian), it is not surprising that several of the Bosnian respondents from Italy were Rom. The Roma are a distinct ethnic minority and have suffered (and continue to suffer) centuries of persecution and discrimination throughout Europe. The Roma people remain among the least integrated and most persecuted peoples in Europe, with frequent violent attacks against Romani immigrants and refugees. Discrimination against Roma is also experienced in employment, education and health care. The interviews revealed that in Bosnia, the Rom people had largely lived settled lives and worked as active members of the labour force. Particularly before the fall of communism in Yugoslavia, the Roma people, as elsewhere in Eastern Europe, had been protected by the state and integrated into society. The fall of communism heralded a new set of post-communist conditions for the Roma people, which throughout Central and Eastern Europe, has resulted in very severe discrimination. Most of the interviewees reported that being Romany completely barred their access to the labour and labour markets in Italy, forcing them to live in temporary camps. The camps lack water, electricity or heating and are characterised by overcrowding and poor hygienic conditions. The camps have been described by some interviewees as extremely detrimental to their health and particularly to the health of their children, who frequently fall ill due to the unhygienic and insanitary conditions. Some Roma people reported having to sell things on the street, barely making enough money to feed themselves, and often resorting to collecting scrap or begging. However, the interviewees emphasised the fundamental importance of family and social networks in the camps, the solidarity of the Bosnian Romani people in the camp, and the assistance they provide to each other.

*Gender discrimination and sexuality*

Other interviewees reported discrimination on other grounds, such as gender and sexuality. In this case, gender discrimination was combined with discrimination on the grounds of the interviewee’s origins:
“(Do you think that within this organisation you have the same possibilities to be promoted as other British workers?) No. (You don’t? Why not?) Because I’m a woman and because I’m not British, and I think that if there is one place, maybe the chambers are more sexist than this, but if there is one place that is based on glass ceilings, it’s XXX. You know, it’s very much like, I mean, the fact that I’m Italian is definitely going to be a handicap. It’s something I always have to prove against. (Have you experienced any direct discrimination in the workplace, anything you can identify clearly as discrimination, or is it just something you feel?) Well, no, I experience verbal discrimination, which is informal jokes, or you know, every day. That’s daily. Directly, yes, I think that ...... Well, I know men who are in my position, and British, who have been promoted before me, who already have a high level in the career, and they didn’t have to ask for it, whereas I haven’t. So I think that, yes, I can definitely prove it on paper.” (Theresa)

The Italian women in the UK in particular, often identified sex discrimination in the workplace as more of an issue than discrimination on the basis of their origins:

“(Have you experienced any direct discrimination because you're not British?) No, I’ve felt more discrimination being a woman. (In what way?) Comments. Comments heard. not directly about me, I mean, not people saying them to me directly, but comments to other senior women colleagues, that I find very offensive. I know a couple of instances, and I actually wrote a letter, but it was never taken up by anybody. I just felt very uncomfortable in a particular incidence. And I heard other comments on gender issues that I didn’t like at all. Basically, not personal attacks to me to my face, which is also a different thing. I can cope, but that kind of nonchalance, that kind of way of saying things just, ‘Oh, by the way’ about other women senior colleagues. It’s just not on….. Not in a public meeting. So I think there are always two measures, two ways of dealing. And I think gender is stronger, still stronger than ..... I think that the gender issue is definitely stronger.” (Tina)

Other issues relating to discrimination also arose around the issue of sexuality. One interviewee from Italy reported that he had left Italy because of his sexuality:

“Yes, because I discovered to be a gay man is difficult in Italy, when I was living in Naples, which is a very heterosexual environment. ...... And there was, of course, a sense of freedom somehow, leaving to this country, and I thought it would be nice to explore my sexuality here differently from in Italy.” (Roberto)

“I started to work in a kitchen as a kitchen porter, and it didn’t last long, because I had difficulties. I had difficulties with one chef, who was from Portugal, and he realised I was gay, so he didn’t like me to be in the kitchen.” (Roberto)

Even within the EU, it can be difficult for homosexual men to live the lifestyle of their choice without being subjected to discrimination. Constructions of masculinity in Italy do not easily incorporate gay men, and in a sense, this migration was instigated by strong push factors in Italy. The move (to the UK) resulted in language problems, deskilling and downward social mobility. This is an issue which may become more important as more countries are incorporated into the EU in the future. While some countries such as the Scandinavian countries and the Netherlands are relatively
tolerant towards their gay communities, there are others which may be less so, and this may create a new but relatively small area of international mobility related to sexuality.

**Conclusion**

This report has attempted to relate a wide range of work-related health issues among a diverse range of migrant groups in Europe. Its purpose is to form a framework for further more focused research in the future, rather than to provide a comprehensive overview of work-related health and migration in Europe. One of the major factors preventing such an overview at this stage has been a lack of appropriate and comparable data sources. The diversity of migrant groups in the study does not allow any clear overall conclusions to be established, but gives clues regarding the types of problems different types of migrants face. The situations for different groups vary enormously. The situation for intra-EU migrants appeared to be fairly positive overall, with most problems being reported in the area of health care. The inclusion of Polish migrants in the project was intended to elucidate some of the problems which can be anticipated when there is greater mobility within an enlarged EU in the future. The issues raised by Poles in the study vary enormously depending on the timing and motives for migration, and the social backgrounds of the interviewees. The problems facing the Bosnian refugees, particularly in relation to deskilling, have emerged as a priority issue which would merit further research among a wider range of refugee groups. This report is being completed at a time when some European governments (notably in Denmark, Italy and Austria) appear to be taking a lurch to the right and adopting extremely hardline tactics against immigration. It is not yet clear how new measures will affect the rights of minorities, or the discrimination they already face in European labour markets, or indeed the possibility of funding for ‘ethnic minority’ research, but in the face of these new emerging trends, the urgency of this research is greater given the increasingly negative tone of some discussions around ethnic minority issues and immigration in general. The largely exclusionary immigration policies in Western Europe jar against a reality where, for mainly demographic reasons, migrant labour is likely to remain an integral part of the economy for all Western European countries in the future.

The findings of the study are broad and therefore at times fragmented, but one of the key issues which has arisen has been the overwhelming importance of family motives for migration, and even when migration has been forced, family networks have played an instrumental role in the choice of destination countries. This means that a large proportion of migration is occurring independently of the requirements of European labour markets. This potentially exposes people to various adaptation problems and to discrimination in the labour market, which has not been anticipated in the general framework of intra-EU labour mobility. Further, even between EU countries, there appears to be an astounding reluctance to recognise and accredit qualifications from other countries. The problem was worse in Sweden and Italy than in Britain, and constitutes a monumental waste of human resources.

Gender roles differ even between western European countries, an issue which has implications for female labour market participation. Some women in the study have preferred to maintain their own cultural norms relating to labour market participation and child care, and others were unable to participate fully in the labour market due to lack of child care facilities. Clearly, any future study should also consider work-related health within the context of the family as well as the labour market.
The role of social networks has featured prominently in nearly all migrant categories, and this, along with the changing and more transient nature of international migration, has implications for the way integration policies are implemented. Some national integration policies do not acknowledge the important functions carried out by social networks, and refugee policies which disperse people and disrupt these networks can have a disempowering effect on the attempts refugees make to overcome the obstacles they face. Social networks have also been seen to be important in the way migrants access health care after migration. Lack of investment in health care in Britain has created standards of care which are deemed unacceptable by some migrants, who use transnational networks to access care in their countries of origin. This has important implications for health care provision in areas with large minority populations.

Deskilling and the links with health, has been identified as a priority area for future research. The observations relating to labour market discrimination and non-recognition of qualifications are major obstacles which contribute to deskilling, along with poor health, which can act as a barrier to employment and retraining. It is important to identify the factors and processes involved in deskilling, and the ways in which these processes interact. The advantage of including multi-faceted aspects of the problem would lie in the ability to provide integrated policy solutions, where issues of health are dealt with in combination with retraining and employment. In this way, measures are more likely to be successful. Accounts have shown that discrimination in various forms is indeed a problem in all three countries in the study, and an understanding of the ways in which discrimination operates is vital.

Overall, with the exception of respondents living in Sweden, very few migrants are trade union members. There are no reports of positive contacts, and in a number of cases, union contacts have been very disappointing. Some measures aimed at including migrants in trade union activities would be useful an all three countries.

Key findings of the pilot project are outlined below:

- The key work-related health problems reported were musculoskeletal and sleeping problems
- Forced migrants suffer greater mental health problems after migration than voluntary migrants
- Intra-EU migration is predominated in this study by family and ‘tied’ migration
- Social networks have played an instrumental role in the migration process among all groups
- Social networks also play an important role in health care provision after migration
- Social networks are the most effective means by which people in the study have gained access to the labour market
- The standard of health care in Britain is viewed as unacceptably poor by many of the people in this study
- Non-recognition of qualifications from abroad constitutes a serious barrier to labour market participation in both Sweden and Italy
- Labour market discrimination in Sweden is a major problem, particularly for the Bosnians
Table 3. Overview of key research findings by country and migrant group

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<tr>
<th>From\To</th>
<th>Italy</th>
<th>Sweden</th>
<th>Britain</th>
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<tr>
<td>Bosnia</td>
<td>Generally high levels of anxiety Social networks very important Problem with non-recognition of qualifications Dangers in the workplace from working illegally Severe discrimination faced by Roma Bosnians</td>
<td>Generally high levels of anxiety Social networks important in finding work Some dissatisfaction with health care Major problem with non-recognition of qualifications Labour market discrimination</td>
<td>Generally high levels of anxiety Social networks well developed Some dissatisfaction with health care</td>
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<tr>
<td>Poland</td>
<td>Social networks important</td>
<td>Social networks important</td>
<td>Social networks important Much dissatisfaction with health care Informal health care networks well developed Dangers in the workplace from working illegally</td>
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<td>Italy</td>
<td>Moderate levels of anxiety Much dissatisfaction with health care Informal health care networks well developed Gender discrimination</td>
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<td>Sweden</td>
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<td>Britain</td>
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<td>Women not active in the labour market</td>
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- Older migrants face particular difficulties, particularly in relation to mental health
- Sweden provides relatively high standards of safety in the workplace for workers
- The role of trade unions has not been important to the people in this study
- The Romani Bosnians in Italy have faced the most severe discrimination of all groups in the study
- Illegal migrant workers may have health problems which are not being treated
- The role of women outside the labour market (working at home) should also be considered in future work
Bibliography


